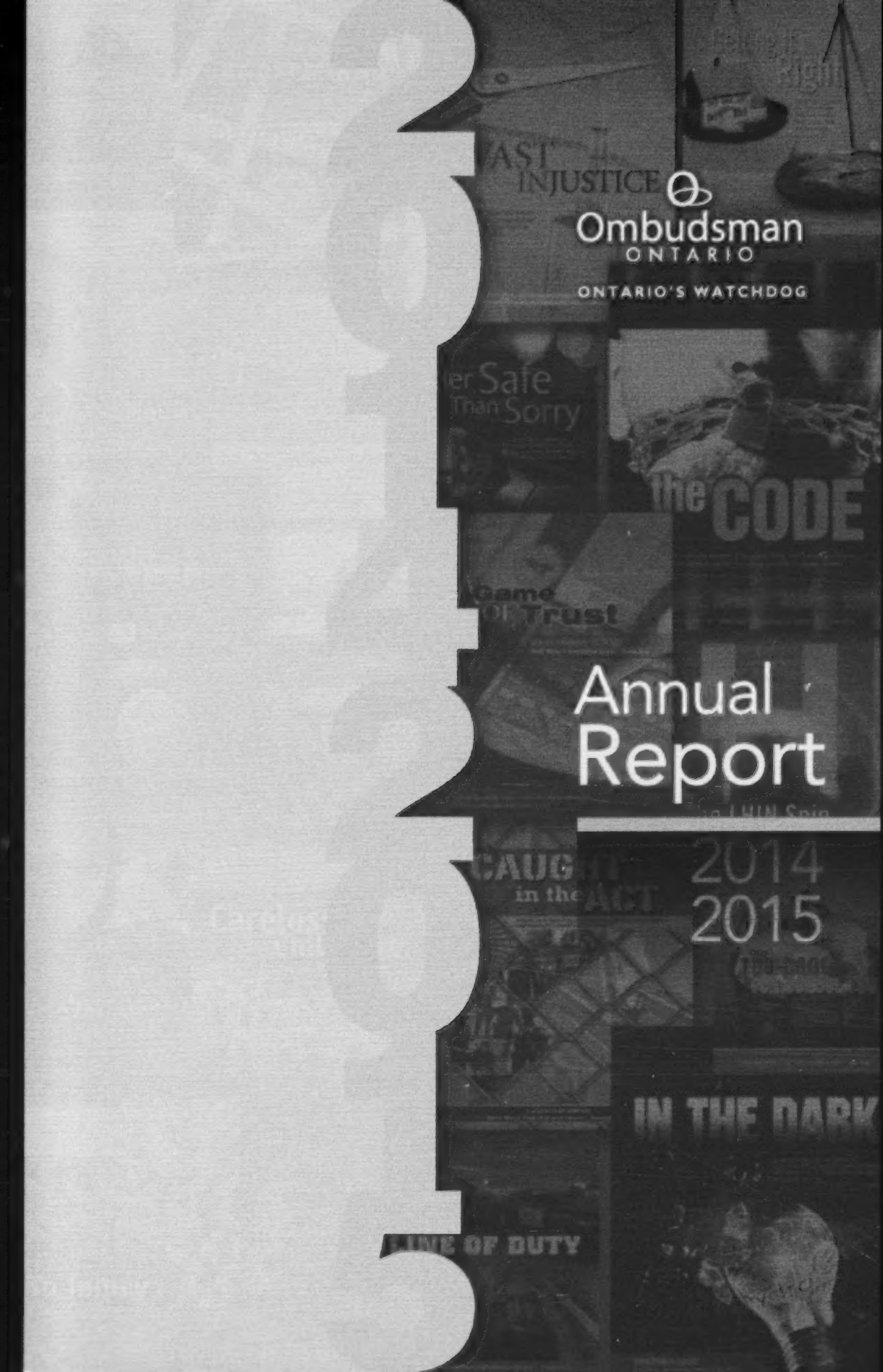
Ombudsman
ONTARIO
ONTARIO'S WATCHDOG
Annual
Report
2014
2015

July 28, 2015

The Honourable Dave Levac
Speaker
Legislative Assembly
Province of Ontario
Queen's Park

Dear Mr. Speaker,

I am pleased to submit my Annual Report for the period of April 1, 2014 to March 31, 2015, pursuant to section 11 of the *Ombudsman Act*, so that you may table it before the Legislative Assembly.

Yours truly,

André Marin
Ombudsman

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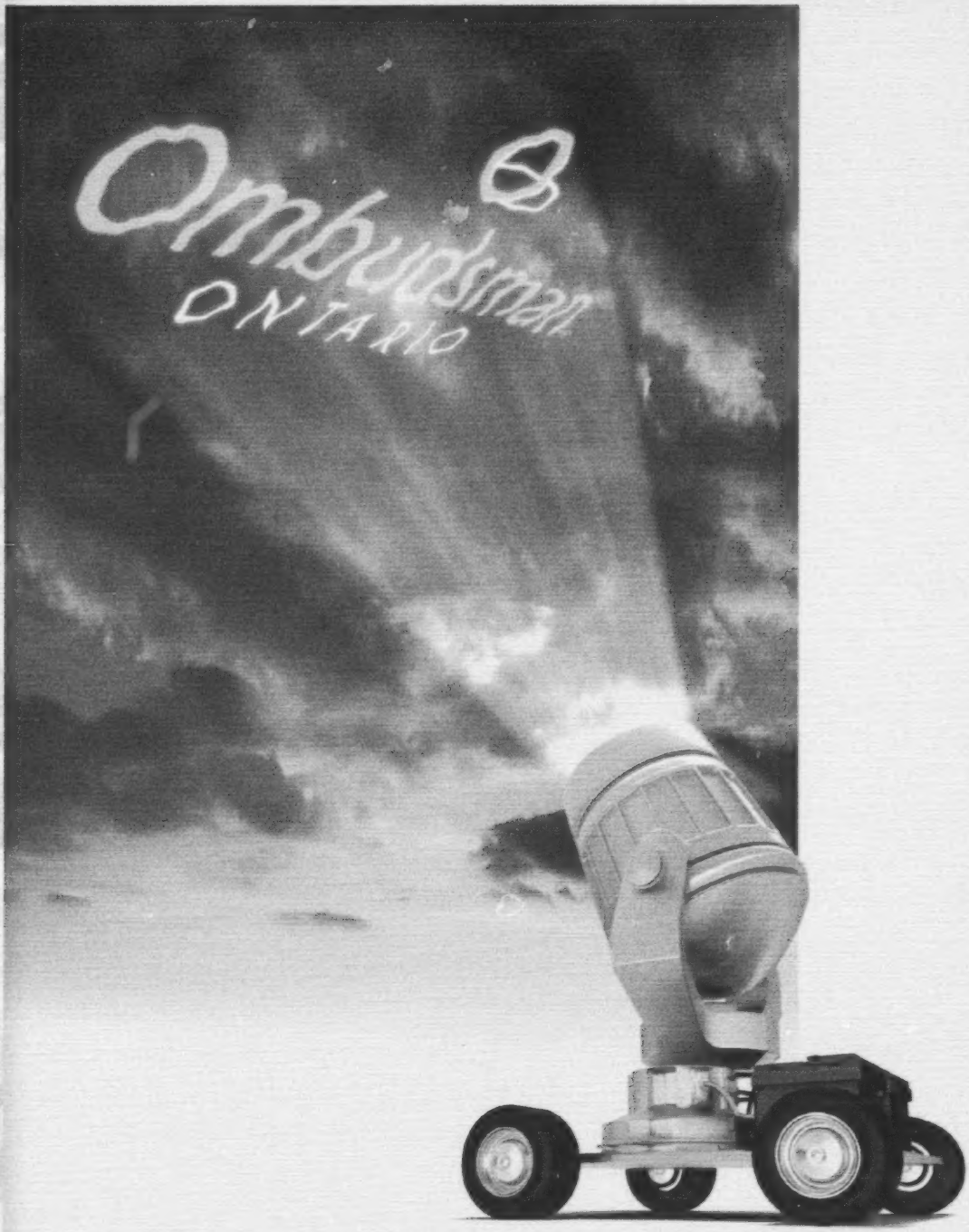

Ombudsman
ONTARIO

Ombudsman's Message: A Decade of Progress

Photo by Brian Miller

This annual report is a milestone for the Ombudsman's Office. We are approaching our 40th anniversary, and I have had the honour of serving Ontarians as Ombudsman for just over 10 of those years. The past decade has been a time of remarkable change and progress in government accountability. Even more lies ahead in the coming months, with the historic expansion of our mandate to municipalities, universities and school boards.

Oversight of the broader public sector is something that this Office has called for since it was established on October 30, 1975, under the first Ombudsman, Arthur Maloney. The *Public Sector and MPP Accountability and Transparency Act, 2014* – known familiarly as "Bill 8" – finally opens these organizations to independent scrutiny comparable to that of provincial government bodies, and brings oversight in Ontario closer to the national norm. We will begin taking complaints about **school boards** on **September 1, 2015**, and **municipalities** and **universities** on **January 1, 2016**. After 10 years of documenting the thousands of complaints in these areas that we were forced to turn away, it is gratifying to be able to share this positive news.

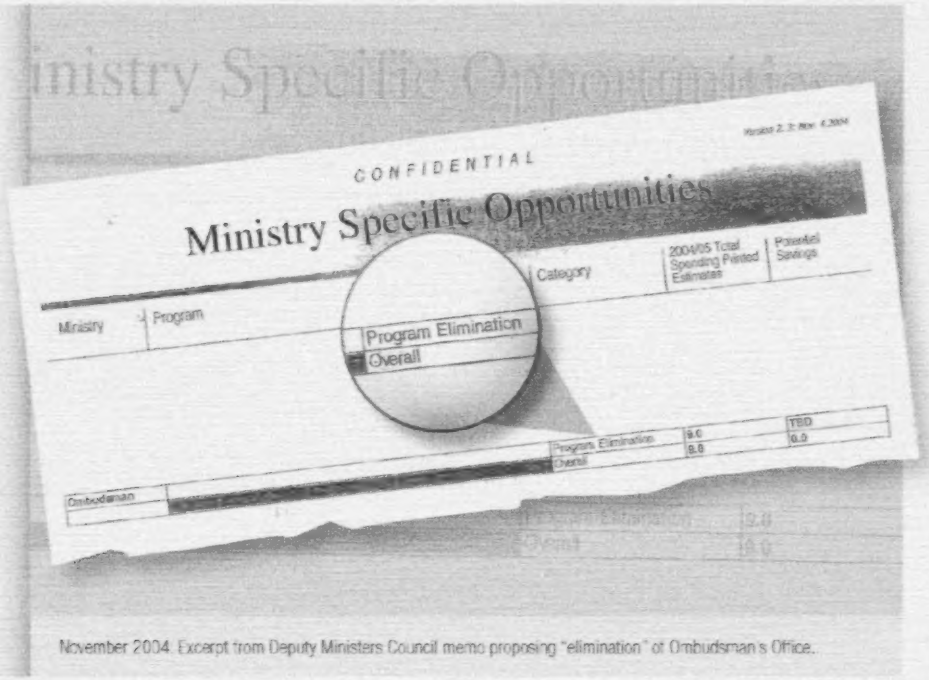
As we mark the end of a decade of constructive work for Ontarians and look ahead to the new challenges and responsibilities that will come with our expanded mandate, this report presents an important opportunity to review not just what we and the government have accomplished in the past year, but to reflect on broader trends and developments of the past 10 years. Overall, the news is good: I have seen real improvements in the way government responds to public grievances and findings of systemic failure – although, as always, there are a few areas where progress remains frustratingly elusive.

Systemic Change, Inside and Out

The Ombudsman's Office was established in 1975 to help Ontarians resolve problems with provincial government services and administration, and to advocate for good governance by exposing underlying systemic weaknesses.

When I took over in 2005, I learned that the Deputy Ministers Council had included the Office on its list of programs targeted for elimination, as a cost-saving measure. Although it was quietly doing good work, the Ombudsman's Office had evolved into an organization that dealt primarily with individual grievances and small administrative problems.

My goal was to return the Office to its roots as the province's watchdog. Facing the threat of being closed down, and without any additional resources, my team and I refocused our operations to allow us to take on the broad systemic issues that affect millions of people, while still resolving thousands of individual complaints each year.



November 2004. Excerpt from Deputy Ministers Council memo proposing "elimination" of Ombudsman's Office.

Highlights of Systemic Investigations: 2005-present

2005

MAY 2005

Children with special needs: Custody of 70 children was restored to parents who had surrendered them to children's aid societies in order to obtain the residential medical care they required.

Report: *Between a Rock and a Hard Place*

2005

SEPTEMBER 2005

Drug funding: The Ministry of Health and Long-Term Care made changes to its drug funding system and paid for a life-saving drug for a teenager whose family was on the verge of bankruptcy.

Report: *From Hope to Despair*

One of our first systemic investigations in 2005 (documented in our report *The Right to be impatient*) revealed the stunning lack of **newborn screening** tests being done on Ontario babies – even though much of the technology was developed here and exported around the world. The government acted swiftly on my recommendations, creating a state-of-the-art facility to test for serious, preventable disorders. In 2005, Ontario was only testing for two medical conditions, lagging behind most developed countries. Today, every baby is screened for 29 disorders, preventing the death or serious disability of some 50 children per year. We continue to keep tabs on the program (as noted in the **Systemic Investigations: Special Ombudsman Response Team** section of this report). It has been a great privilege to help bring about such positive, pervasive change that is still helping families today.

> "Thank you for your advocacy. Baby Etienne is doing great because they caught the disorder before he could get sick."
>
> – TWITTER FOLLOWER (RE NEWBORN SCREENING), NOVEMBER 2014

Since 2005, we have completed **35** systemic investigations into a wide range of issues – from care for children with acute **special needs** (also 2005-2006) to the billing and customer service fiasco at **Hydro One** this past year. The government has agreed with all but a handful of our recommendations, resulting in reforms that have helped parents, property taxpayers, lottery players and millions of others. We handled **193,038** individual complaints over that period – **23,153** in 2014-2015. And throughout this time, we have kept the cost of running our Office (**$11.36 million** this past year) well below $1 per Ontarian.

I have always believed that the Ombudsman's job is not only to help people, but to reveal some of the problems that government faces, and the progress it is making towards fixing them. An invisible ombudsman is an ineffective ombudsman. Being in the public eye and ensuring that our reports make an impact is an important part of our work. When we root out problems affecting large numbers of people and the government implements our proposed solutions, we help government avert more complaints, while demonstrating to the public that coming to us really can make a difference.

This inspiration has driven our work over the past 10 years: Conducting large-scale field investigations that are now a model for our counterparts across North America and around the world; working proactively with government to resolve problems before they fester; and using technology to allow us to track complaint trends, enrich our investigations, publicize our work and engage with the public. By all measures, Ontarians have heard the watchdog's bark: Tens of thousands engage with us on social media, millions have heard about us in the news, and public complaints have steadily increased – **86%** since 2009-2010. (More details can be found in the **Communications and Outreach** and **Training and Consultation** sections of this report.)

2005

SEPTEMBER 2005

Newborn screening: Babies were only being tested for two medical disorders; this was increased to 29, averting death or severe illness for 50 infants per year.

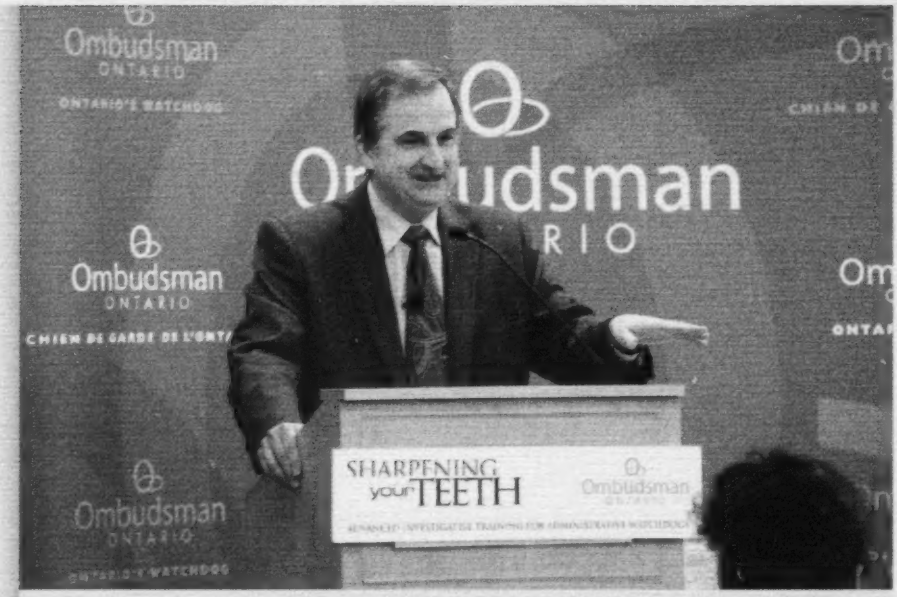
Report: The Right to be Impatient

2006

MARCH 2006

Property tax assessments: The government froze assessments for two years as the Municipal Property Assessment Corporation implemented the Ombudsman's recommendations to improve fairness, transparency and accuracy.

Report: Getting it Right



January 20, 2015: Steve Orsini, Secretary of the Cabinet and head of the Ontario Public Service, speaks to delegates at the Ombudsman's annual "Sharpening Your Teeth" training conference.

A Partnership for Accountability: The Good News

One of the most constructive developments I have observed over the past decade is an improvement in government's response to citizen complaints and an increased level of co-operation on issues, large and small.

In the early days of my tenure, it would often take a full systemic investigation to prompt government action. Now, many complaints and issues can be resolved quickly and informally because of good relationships between my Office's staff and the Ontario public service. The co-operation starts at the top. I have had quarterly meetings with the Secretary of the Cabinet (who is also the head of the public service), to discuss issues and trends and how government services can be improved. Senior managers from our Office also meet regularly with high-ranking officials in the most complained-about ministries and organizations to flag problems before they grow. This has resulted in us resolving many systemic issues without resorting to a full-scale investigation.

2006

MAY 2006

Disability support: Ontario Disability Support Program recipients received payments that had been unjustly delayed for nine years, and regulations limiting retroactive payments were revoked.

Report: Losing the Waiting Game

2006

MAY 2006

Testicular implants for boys: The Ministry of Health and Long-Term Care restored funding for testicular prosthesis surgery for boys under 18. Because the matter was resolved, no report was issued.

For example, in recent years, we have worked closely with the Ministry of Community Safety and Correctional Services to resolve and track serious issues **involving inmate safety and medical care**. Our approach since 2005 has been to ensure that most complaints we receive from correctional facilities are resolved quickly by the facilities themselves, while we concentrate on urgent matters relating to health and safety. Among the serious issues we flagged to the Ministry recently are the treatment of transgender inmates, the inappropriate use of segregation, and inadequate response to inmate-on-inmate violence.

We also worked with the Ministry of Colleges, Training and Universities this year to resolve a flood of complaints after the sudden closure of **Everest College**'s 14 private career training campuses, which left some 2,700 students in the lurch. Although overwhelmed at first by the dire needs of many students, the Ministry worked with us to help them get back on track. (More information about these proactive efforts can be found in the **Operations** section of this report.)

When we did conduct systemic investigations, the results were overwhelmingly positive. This past year, our investigation into how the Ministry of Education monitors **unlicensed daycares** is a case in point. After our investigation uncovered an outdated and inadequate system of investigation that put children at risk – not to mention a litany of bureaucratic missteps that I recommended be used as a teaching tool in future for what NOT to do – the government's response was swift and uncompromising: All 113 recommendations were accepted, and new legislation that addresses many of them was passed mere weeks after my report, *Careless About Child Care*, was published.

There was similar positive follow-up to *In the Line of Duty*, our 2012 report on operational stress injury and suicide among **OPP** and police, and *The Code*, our 2013 report on the **excessive use of force** by correctional officers. The OPP and, in both cases, the Ministry of Community Safety and Correctional Services, reported significant progress on implementing my recommendations. The same Ministry also finally saw a key recommendation fulfilled from my 2010 report on the expansion of police powers during the **G20** in Toronto, *Caught in the Act*: The government passed long-promised legislation to replace the World-War-II-era *Public Works Protection Act*, ensuring it could never again be used to enable mass violations of civil rights.

There was good news on the accountability front, too, from many municipalities where our Office is the investigator for complaints about **closed meetings**, a responsibility we have had since 2008. More municipalities – **203** as of March 31, up from 195 a year ago – are using our Office as their investigator, and a growing number (now about a dozen) have accepted my recommendation that they digitally record their closed meetings, to ensure accuracy. Newly elected councils – including in cities where our Open Meeting Law Enforcement Team (OMLET) investigations met with resistance in the past, such as Sudbury and London – have pledged to be more transparent, which bodes well for Bill 8, and is also a credit to members of the public who made their feelings known through civic activism, social media and the ballot box. (Our separate **OMLET Annual Report** will be published later in the fiscal year.) The new mayor of Brampton even proposed to have my Office conduct a public inquiry in the wake of a corruption scandal in that city – however, special dispensation from the provincial government was not granted, meaning consideration of the matter will have to wait until our Bill 8 mandate is in effect.

2006

AUGUST 2006

Delinquent child support: The Family Responsibility Office agreed to improve enforcement of support orders and close loopholes.

Report: *It's All in the Name*.

2007

JANUARY 2007

Out-of-country cancer care: The Ministry of Health and Long-Term Care overhauled its out-of-country care program and repaid $75,000 to a chemotherapy patient. Because the matter was resolved, no report was issued.

> "Your response to [a constituent]'s request by having a representative from your Office call to discuss his concerns so speedily is admirable. It is heartening to me, as a member of the Legislature, to know that we have – in you – an officer who takes his duty to serve the public of Ontario so seriously."
>
> ▸ LETTER FROM JOHN YAKABUSKI, PC MPP, RENFREW-NIPISSING-PEMBROKE, MARCH 2015

> "I hold the Ontario Ombudsman's Office in the highest regard. The Office is made up of intelligent, concerned, hard-working people who have nothing but the best interests of the Ontario public in heart and mind. I thank them very much for their efforts and well reasoned arguments, win, lose or draw. If asked, I support without reservation, the Ontario Ombudsman's oversight of the MUSH sector."
>
> ▸ EMAIL FROM TINY TOWNSHIP MAYOR RAY MILLAR, SEPTEMBER 2014

Our Office worked constructively with MPPs over the past decade as well, resolving hundreds of complaints from their constituents and issues that they referred personally. MPPs of all parties have shown strong support for the Office in recent years, another sign of how far we have come from the days when its very existence was threatened. The expansion of our role through Bill 8 was the culmination of many years of calls by MPPs for Ombudsman oversight of the broader public sector, through private member's bills and the tabling of public petitions in the Legislature – **16** of the former since 2005 alone, and **142** of the latter.

2007

FEBRUARY 2007

Compensation for crime victims: The Ministry of the Attorney General committed $20 million to aid crime victims and to reform a cash-starved compensation system that was revictimizing crime victims.

Report: Adding Insult to Injury

2007

MARCH 2007

Lotteries: The Ontario Lottery and Gaming Corporation overhauled lottery security after it was was found to have paid out tens of millions of dollars in prizes to "insiders."

Report: A Game of Trust

... And the Not-so-good News

Looking at 10 years of public complaints and major investigations, certain themes emerge. A lot of our time has been devoted to reminding uncaring and rigid bureaucracies of their duty to serve the public and the human consequences of their actions. We have seen plenty of improvements, but some organizations are resistant, unable or unwilling to change. At times, it can feel like one step forward, two steps back.

The **Family Responsibility Office** (FRO) and **Ontario Disability Support Program** (ODSP) are consistently among our "Top 5" complaint-getters. Although we have a constructive relationship with these organizations and have worked with them through some big challenges, new ones are constantly cropping up. Last year, we reported on a communication breakdown between both agencies that deprived thousands of FRO recipients of money owed to them; this year, the ODSP was awash with new complaints due to glitches in the brand-new Social Assistance Management System (SAMS), launched in November 2014.

May 21, 2015: Ombudsman André Marin and Auditor General Bonnie Lysyk make joint submission to the Standing Committee on Finance and Economic Affairs, urging continued independent oversight of Hydro One.

2007

APRIL 2007

Psychological services for military children: Provincial and federal officials committed emergency funding to help traumatized children of Ontario-based Canadian Forces personnel serving in Afghanistan. Because the matter was resolved, no report was issued.

2007

NOVEMBER 2007

Assistive devices: The Ministry of Health and Long-Term Care agreed to fund home use of oxygen saturation monitors for children with life-threatening conditions, and to review the entire Assistive Devices Program. Because the matter was resolved, no report was issued.

In my first term, our investigations of the **Municipal Property Assessment Corporation** (2006) and the **Ontario Lottery and Gaming Corporation** (2007) exposed how badly things can go wrong when public corporations forget their duty as public servants. The results were good news – MPAC's assessment process became more transparent and fair, and the lottery system now offers players protection against insider theft and fraud. Unfortunately for **Hydro One**'s thousands of overbilled and underserved customers, it had to learn this same lesson all over again this year, in the wake of the disastrous introduction of its new customer information system in 2013. The utility accepted 65 of the 66 recommendations in my May 2015 report, *In the Dark*, including that it put its duty to the public first. The bad news was that, thanks to the government's plan to partially privatize Hydro One, it was removed from my oversight (and that of all my fellow officers of the Legislature), sadly leaving my 66th recommendation unfulfilled.

> "Given the corporation's checkered billing and customer service history, the government's continuing investment in this major energy provider, and the overriding public interest in ensuring accountability and transparency, Hydro One should remain subject to oversight by the Office of the Ombudsman, and my fellow Legislative Officers."
>
> ▸ OMBUDSMAN ANDRÉ MARIN, SUBMISSION TO COMMITTEE HEARING ON BILL 91, MAY 2015

Similarly, despite two investigations – in 2008 and 2011 – demonstrating the need for stronger legislation to support the **Special Investigations Unit** in its important work in holding police to account, the government's response has been disappointing. It has paid lip service to the concept of civilian oversight, which benefits police as well as the public, but successive Attorneys General have been silent on giving it the legislative teeth it needs to ensure police co-operate with its investigations. Policing remains the area where it has been most difficult to effect change in the past 10 years.

I will have more to say about police co-operation later this year when I report on my most recent investigation, involving how the province trains and directs police officers in the **de-escalation** of potential conflicts with people in crisis. Because it affects police directly, I invited the input of every police service, chief and association, even though I do not oversee them. The response was mixed, although those who co-operated did so constructively. I look forward to sharing the results of that report with the public and policing community soon.

2008

FEBRUARY 2008

Legal Aid: The Ministry of the Attorney General and Legal Aid Ontario took action to recover assets and strengthen the oversight of public funds spent in criminal trials after $1.2 million was spent to defend Richard Wills.

Report: *A Test of Wills*

2008

JUNE 2008

Protection of new homeowners: The Ministry of Government and Consumer Services improved transparency of Tarion Warranty Corporation and created an internal ombudsman.

Report: *Building Cavity*

Life, Death and Rulitis

Most disturbingly, some of the weakest areas of performance we've observed have involved government services that can literally be matters of life and death. In addition to policing, these include the myriad organizations that deal with all aspects of health care – from treatment to insurance to home supports – and the many agencies that assist people with complex special needs.

Many families come to us exhausted and desperate from having to navigate multiple provincial ministries, Local Health Integration Networks, Community Care Access Centres, and a multitude of ministry-funded local service providers to get help. It's no surprise that the links between all of these organizations are sometimes weak.

2008

SEPTEMBER 2008

Oversight of police: The Special Investigations Unit hired more civilian investigators to address concerns of pro-police bias and increased the rigour of its investigations.

Report: *Oversight Unseen*.

2009

JULY 2009

Private career colleges: The Ministry of Training, Colleges and Universities began laying charges under the *Private Career Colleges Act* after it failed to protect students from an illegal college that abruptly shut down.

Report: *Too Cool For School*.

My very first systemic investigation in 2005, detailed in my report *Between a Rock and a Hard Place*, exposed the heart-wrenching choice faced by parents of children whose extreme **special needs** required them to be placed in residential care. They were told that the only way to get such placements was to surrender their custody to children's aid societies. After we exposed this unjust situation, custody of some 70 children was returned to their parents. However, similar cases continue to come to our attention from time to time, usually because of a lack of communication or understanding between agencies and government-funded services. We resolved six such cases this past year, in four different areas of the province.

On a related note, our work continues on our most complex investigatic to date, into services for **adults with developmental disabilities who are in crisis.** As difficult as it is to find placements for children with severe and complex special needs, the problem is exacerbated once those children become adults. We have received more than 1,300 complaints since launching this investigation in late 2012, many involving people with developmental disabilities who have ended up in homeless shelters, hospitals and even jail because there is nowhere for them to go. Wherever possible, our staff have worked to ensure the various agencies and service providers come together to resolve individual crises; meanwhile, our systemic investigation is nearly complete and I plan to release my report and recommendations later this year.

Our focus on the individual human impact of these cases has been key to our success. In 2006, I referred to the all-too-common bureaucratic malady that I dubbed **"rulitis"** – adherence to rules at the expense of common sense. We continue to see outbreaks of rulitis, which is often most acute and toxic in the area of health care, especially when medical evidence collides with arbitrary rules.

For example, the Ministry of Health and Long-Term Care was refusing to fund a particular chemotherapy drug for a woman experiencing a third occurrence of breast cancer, because its rule was that it would only cover second occurrences. We worked with the woman's doctor and the Ministry to get a temporary revision of the funding criteria – a change that will benefit an estimated 100 women over the next three years.

The Ministry also established an appeal process for exceptional cases where northern Ontario patients have to travel for treatment, after we flagged the case of a woman who was denied Northern Health Travel Grant compensation because her trip was just seven kilometres short of the required 200. And it improved the frustrating, convoluted customer service system at Trillium Drug Program that forced a woman to write three different letters to confirm her insurance was running out and she urgently needed funding for her medication.

In another case, after a woman complained that she was forced to pay $7,000 to enroll her daughter in a substance abuse program while government-funded spots in the same program sat empty, we persuaded the Local Health Integration Network to arrange for the program to refund her money and improve its rules for screening program applicants.

Stories like these represent not just "wins" for our Office, but for the public and government alike. (Examples of more individual cases where our staff made a difference can be found in the **Case Summaries** section of this report.)

2009

AUGUST 2009

Community college programs: The Ministry of Training, Colleges and Universities issued new directives on advertising of programs like Cambrian College's Health Information Management program, whose graduates were unable to find jobs in their field.

Report: *Too Cool For School Too.*

2009

SEPTEMBER 2009

Drug funding – Avastin: The Ministry of Health and Long-Term Care agreed to lift its arbitrary funding cap on colon cancer drug Avastin.

Report: *A Vast Injustice*

Big Challenges Ahead

Our experience of the past decade has positioned this Office well for the first major expansion of our mandate since 1975. Since the introduction of **Bill 8** a year ago, we have been preparing for our new responsibility by researching and reaching out to municipalities, universities and school boards. My staff and I have made numerous presentations to stakeholder groups in these areas, and we will ensure they and the public are well informed about what to expect when we open our doors to new complaints, starting with school boards this September.

We are already well aware of some of the significant complaint areas, having tracked complaints from the so-called "**MUSH**" sector (**m**unicipalities, **u**niversities, **s**chool boards, **h**ospitals and long-term care homes, as well as children's aid societies and police) since 2005. Fiscal 2014-2015 was no exception, since Bill 8 was still not in effect, and complaints about MUSH organizations continued to pour in – **3,383**, just under last year's peak of 3,400. Clearly, public demand indicates that oversight of this sector cannot come soon enough.

Bill 8 will bring **municipalities** (always the largest source of MUSH complaints, with a record **1,656** this past year) under my Office's direct jurisdiction, as well as **universities** (with a remarkable **72** complaints this year) and **school boards** (**260** complaints). Although it does not give this Office direct oversight of hospitals and long-term care – something ombudsmen in most other provinces have – we will oversee the new Patient Ombudsman, whenever it is created. And while Ontario's child protection system will remain the only one in Canada without Ombudsman oversight, it will finally be open to independent scrutiny now that my fellow officer of the Legislature, the Provincial Advocate for Children and Youth, has been given investigative powers under Bill 8.

2010

AUGUST 2010

LHIN public engagement: Local Health Integration Networks were told to stop holding illegal closed "education" meetings after the Hamilton Niagara Haldimand Brant LHIN inadequately engaged the public in health care restructuring decisions.

Report: *The LHIN Spin*.

2010

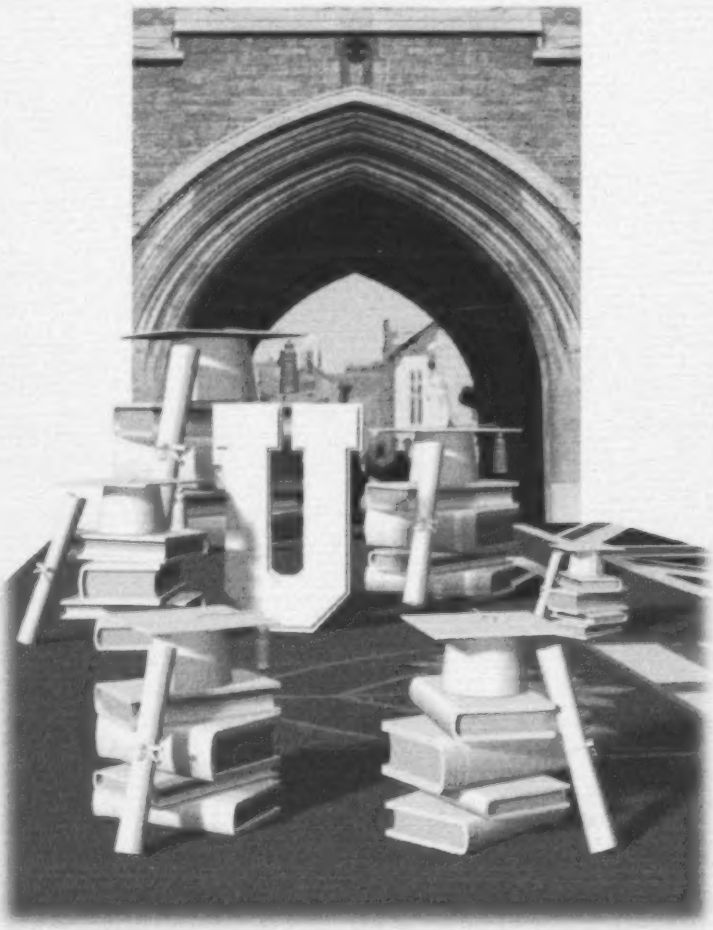
DECEMBER 2010

G20 summit: The World-War-II-era law that was wrongly used to expand police powers and breach civil rights during the June 2010 Toronto G20 summit was replaced.

Report: *Caught in the Act*.

It is worth noting that, even when all of the new oversight enabled by Bill 8 is in place – and to be clear, as of the writing of this report, no date had been set for the establishment of the Patient Ombudsman or the Child Advocate's new powers – Ontario will still lag behind much of Canada in this area. Oversight of police will not change at all. And our "MUS" oversight, while welcome, is hardly revolutionary – **five** other provincial and territorial ombudsmen already oversee municipalities and school boards, and **two** oversee universities. (More details can be found in the next section of this report: **Beyond Scrutiny: MUSH Sector Complaints**.)

As part of our preparations for our new responsibilities, my Office has partnered with Canada's Public Policy Forum, which will convene stakeholders in all three parts of the "MUS" sector, to hear their concerns and inform them about the workings of our Office and Bill 8, in a series of roundtable meetings and an informational conference this fall.



It will be important for all stakeholders to understand the Ombudsman's role as a **last resort** – a place for complainants to turn when local avenues hit a dead end. As the many stories in this report illustrate, the bulk of our work involves resolving problems quickly by referring them to the appropriate officials, and offering fresh eyes to examine troublesome issues. We do not replace existing complaint mechanisms; we ensure they work as they should.

2011

MAY 2011

Drug funding – Herceptin: The Ministry of Health and Long-Term Care agreed to begin funding Herceptin for patients with breast cancer tumours of one centimetre in diameter or less. Because the matter was resolved, no report was issued.

2011

JUNE 2011

Non-emergency medical transportation services: The Ministries of Transportation and Health and Long-Term Care pledged to regulate the medical transportation services industry. Because the matter was resolved, no report was issued.

Municipalities, for example, have the power to establish codes of conduct and create their own strong accountability offices, such as ombudsmen, auditors general and integrity commissioners. The principle of accountability envisioned by Bill 8 is not to have the Ombudsman usurp that power, but to strengthen and support local complaint offices, ensuring they provide effective and consistent service.

Universities already have some experience with Ombudsman work, although just 57% have internal ombudsmen. I and my senior team have met with university presidents and ombudsmen from across Ontario to encourage them to establish and strengthen those roles. We have offered training for university ombudsmen and addressed student groups about how we will handle complaints, drawing on our long experience in investigating issues with colleges of applied arts and technology.

School boards will be our first entry into the new "MUS" area, and I have encouraged them to bolster their local accountability mechanisms as well. As we do in our provincial work, we will refer complaints to local authorities for resolution wherever possible, but we will be there to help trustees, board staff, parents and students deal with issues when local solutions fail.

Building on the progress we have made over the past decade, including an effective team, tried-and-true procedures and investigative methods that are now emulated around the world, we look forward to taking on this historic new responsibility.

2011

DECEMBER 2011

Government support for police oversight: The Ministry of the Attorney General was found to be failing to support the Special Investigations Unit (SIU) in its role as police watchdog.

Report: *Oversight Undermined*

2012

OCTOBER 2012

OPP handling of operational stress injuries: The Ontario Provincial Police and Ministry of Community Safety and Correctional Services agreed to address operational stress injuries and suicide among police officers.

Report: *In the Line of Duty*

To the Next 40

It has been a privilege to serve this province through this remarkable decade, and to guide this Office toward its 40th anniversary amid such strong support from the public and government. This appreciation for our Office's work is demonstrated in our complaint numbers, public comments and genuine, lasting improvements in government services that have helped millions of people. Soon, we will be able to help millions more, thanks to the vote of confidence given to us through Bill 8. We will be ready when Ontarians call.

Illustrations from past Annual Reports highlight the barriers to Ombudsman scrutiny of hospitals (2011-2012), children's aid societies (2012-2013), and municipalities (2013-2014).

2013

JUNE 2013

Use of force in jails: The Ministry of Community Safety and Correctional Services pledged to eradicate the 'code of silence' and improve investigations of excessive use of force by correctional officers.

Report: *The Code*

2014

APRIL 2014

Monitoring of hypoglycemic drivers: The Ministry of Transportation improved monitoring of drivers with uncontrolled hypoglycemia and other medical conditions that may pose a danger on the roads.

Report: *Better Safe Than Sorry*

"[We have] received a substantial number of complaints directed against... Boards of Education, universities, public hospitals and municipalities. ... Because these bodies have important decision-making powers and take actions which affect the lives of all of us, and further because ... they are identified with the provincial government in view of the monies received by them from the government, it is my intention to recommend to the Legislature that I be given the requisite jurisdiction to investigate complaints respecting these institutions."

▶ ARTHUR MALONEY, ONTARIO'S FIRST OMBUDSMAN, SPEECH MARKING THE OFFICE'S FIRST ANNIVERSARY, OCTOBER 1976

"I wish I could take full credit for this initiative, but I cannot. It was the idea of Arthur Maloney, the first Ombudsman... I want more power for this Office so that the people of Ontario can have the benefits of an effective government watchdog when they have their most frequent and, often, most important contacts with government ... I will continue throughout my mandate to push to remedy the jurisdictional failings of this Office."

▶ OMBUDSMAN ANDRÉ MARIN, ANNUAL REPORT 2005-2006

"The legislation we are proposing would extend the mandate of the Ombudsman – one of the bedrocks of accountable government...We want Ontarians to trust that their public institutions are acting responsibly, and so we're proposing to extend the Ombudsman's oversight to municipalities, school boards, and publicly funded universities."

▶ JOHN MILLOY, THEN MINISTER OF GOVERNMENT SERVICES, APRIL 2014

2014

OCTOBER 2014
Unlicensed daycares: The Ministry of Education replaced antiquated legislation and tightened rules to better protect children in unlicensed daycares.
Report: *Careless About Child Care*

2015

JUNE 2015
Hydro One billing and customer service: The utility committed to improving its billing and customer service practices to put the public first.
Report: *In the Dark*

The Year in Review

Beyond Scrutiny: MUSH Sector Complaints

Since its inception in 1975, our Office has had to turn away thousands of complaints about the broader public sector – also called the MUSH sector: **M**unicipalities, **U**niversities, **S**chool boards and **H**ospitals, as well as long-term care homes, children's aid societies and police. The first Ombudsman of Ontario, Arthur Maloney, made the case that the Office's jurisdiction should be expanded into that sector, and successive ombudsmen have repeated the call, even as their counterparts in every other province were able to help citizens with MUSH complaints.

For the past 10 years, our Office has reported on the number and nature of complaints we received about the MUSH sector, the calls for change (public petitions and private member's bills tabled in the Legislature), and how Ontario lagged behind all other provinces in ombudsman oversight of this area.

This year marks the turning point: With school boards coming under the Ombudsman's jurisdiction in September 2015 and municipalities and universities in January 2016, the MUSH sector will no longer be "beyond scrutiny." With that in mind, this section reviews key developments relating to MUSH sector oversight in Ontario, leading up to the **3,383** cases received in 2014-2015 – just under last year's record of 3,400.

COMPLAINTS RECEIVED ABOUT MUSH SECTOR ORGANIZATIONS 2005-2006 TO 2014-2015

	MUNICIPALITIES	UNIVERSITIES	SCHOOL BOARDS	HOSPITALS	LONG-TERM CARE HOMES	CHILDREN'S AID SOCIETIES	POLICE	TOTAL BY YEAR
2005-2006	1,104	28	87	211 total		436	N/A	1,866
2006-2007	1,043	37	102	237 total		600	376	2,395
2007-2008	939	31	79	276 total		431	373	2,129
2008-2009	858	49	107	532 total		429	361	2,336
2009-2010	623	23	110	205	28	296	228	1,513
2010-2011	758	39	99	291	34	386	356	1,963
2011-2012	1,045	50	119	383	19	491	432	2,539
2012-2013	1,077	55	133	369	70	472	365	2,541
2013-2014	1,595	41	147	471	72	536	538	3,400
2014-2015	1,656	72	260	475	84	478	358	3,383
Total by category	**10,698**	**425**	**1,243**	**3,757**		**4,555**	**3,387**	
Total MUSH sector complaints, April 1, 2005 to March 31, 2015: 24,065								

The 10-year 'Push for MUSH'

Efforts to bring ombudsman oversight to MUSH date back to the first Ontario Ombudsman, Arthur Maloney, who began arguing for the Office's mandate to be extended in 1975. After he left office, he issued an extensive "Blueprint" report documenting his arguments on March 29, 1979.

In this photo from Annual Report 2011-2012 a woman hands out her own leaflets in support of expanded Ombudsman oversight in October 2011.

In subsequent years, Ombudsman oversight eroded as the government grew. For example, significant consumer protection and safety standards were put in the hands of private bodies, and public housing was downloaded onto local governments, placing these organizations outside the Ombudsman's reach. Ten provincial psychiatric hospitals, previously within the Ombudsman's authority, were transferred to the hospital sector, removing psychiatric patients' access to our Office.

Meanwhile, other provinces expanded the jurisdiction of their ombudsmen in the MUSH sector, to the point where Ontario lagged far behind, particularly in oversight of hospitals, long-term care homes and children's aid societies. Ontario did give the Ombudsman the additional responsibility of investigating complaints about closed municipal meetings in 2008, but this was limited only to enforcement of the open meeting rules in the *Municipal Act, 2001* – and municipalities could opt out of Ombudsman oversight by hiring their own investigators.

Public demand for change intensified over the past decade. Since 2005 alone, there have been **16** private member's bills to give the Ombudsman oversight of all or part of the MUSH sector (including **two** this year), and **142** petitions tabled in the legislature with the same goal, including **11** this year.

The Ombudsman reported in his 2013-2014 Annual Report that then-premier Dalton McGuinty met with him in June 2012 to discuss extending his mandate to hospitals, long-term care and children's aid societies. However, the first official government move to amend the *Ombudsman Act* came in March 2014 under Premier Kathleen Wynne, exactly 35 years after Arthur Maloney's "Blueprint." First introduced as Bill 179, the *Public Sector and MPP Accountability and Transparency Act, 2014* died on the order paper due to the June 2014 election, but was reintroduced as **Bill 8** – and passed on December 9, 2014.

Among many other broad accountability measures, the legislation gives the Ombudsman oversight of the "M," "U" and "S" of the sector – municipalities and universities as of January 1, 2016; school boards as of September 1, 2015. It does **not** extend Ombudsman authority to hospitals, long-term care or child protection. Instead, it will create a separate Patient Ombudsman for complaints about hospitals and long-term care, reporting to the Minister of Health and Long-Term Care through Health Quality Ontario, which the Ombudsman **does** oversee. The powers of the Provincial Advocate for Children and Youth will be expanded to include investigations of children's aid societies. Oversight of police does not change under Bill 8.

As the accompanying chart shows, the changes under Bill 8 bring Ontario forward in some areas of MUSH sector oversight, but ombudsmen in most other jurisdictions have comparable or broader mandates.

HOW THE ONTARIO OMBUDSMAN'S MANDATE COMPARES TO OTHERS' IN MUSH SECTOR

	MUNICIPALITIES	UNIVERSITIES	SCHOOL BOARDS	PUBLIC HOSPITALS	LONG-TERM CARE HOMES	CHILD PROTECTION SERVICES	POLICE COMPLAINTS REVIEW MECHANISM
Ontario	YES, as of Jan. 1, 2016	YES, as of Jan. 1, 2016	YES, as of Sept. 1, 2015	Oversight of Patient Ombudsman once it is in place		No	No
British Columbia	Yes	Yes	Yes	Yes	Yes	Yes	No
Alberta	No	No	No	Yes	Yes	Yes	Yes
Saskatchewan	No	No	No	Yes	Yes	Yes	Yes
Manitoba	Yes	No	No	Yes	Yes	Yes	Yes
Quebec	No	No	No	Yes	Yes	Yes	Yes
New Brunswick	Yes	No	Yes	Yes	Yes	Yes	Yes
Newfoundland and Labrador	No	Yes	Yes	Yes	Yes	Yes	Yes
Nova Scotia	Yes	No	Yes	Yes	Yes	Yes	Yes
Yukon	Yes	No	Yes	Yes	Yes	Yes	No

"M" – Municipalities

Municipalities have consistently been the top source of MUSH sector complaints to our Office. Fittingly, this was the first part of the MUSH sector that the province opened to greater accountability – including limited Ombudsman oversight. In 2007, provisions of the *Municipal Statute Law Amendment Act* took effect, allowing all municipalities to appoint their own accountability officers, such as an ombudsman, auditor general, integrity commissioner and lobbyist registrar. At that time, the Ombudsman committed to monitoring the development of these oversight mechanisms:

> "Although this Office does not have formal jurisdiction over municipalities or any ombudsmen they might appoint, because of the very high degree of influence which municipal government decisions have on the lives of all Ontario citizens, [we intend] to monitor the development of oversight mechanisms in all... municipalities. Special attention will be paid to municipalities which fail to establish offices or set up offices that are weak or tokenistic."
>
> – OMBUDSMAN ANDRÉ MARIN, ANNUAL REPORT 2006-2007

In 2008, changes to the *Municipal Act, 2001*, came into force, requiring that municipalities either appoint an investigator for public complaints about closed municipal meetings or rely on the Ombudsman, who was designated the default investigator for such complaints. Municipalities were permitted to hire their own investigators if they so chose.

As of the writing of this report, very few municipal accountability officers exist. The only municipality to appoint its own ombudsman is Toronto, which was required to do so under the *City of Toronto Act*; only Toronto and Ottawa have auditors general in place, and roughly 30 of Ontario's 444 municipalities have integrity commissioners.

The Ombudsman was the closed meeting investigator for **203** municipalities across the province as of March 31, 2015, and received **152** closed meeting complaints in fiscal 2014-2015. Reports on these investigations, conducted by the Ombudsman's Open Meeting Law Enforcement Team (OMLET), are posted on our website and reviewed in our separate OMLET Annual Report, to be released later this fiscal year.

We received a record **1,656** complaints and inquiries about municipalities in 2014-2015. Some **247** of these related to municipal electricity utilities, likely due to the Ombudsman's investigation into billing and customer service problems at the provincially-run Hydro One.

Among these complaints were allegations of conflicts of interest amongst councillors, inadequate by-law enforcement, substandard conditions in public housing, problems with access to support and service at Ontario Works, and inadequate public consultation about zoning and property development issues.

One man complained that his municipality allowed a "river" of storm water from 22 adjacent properties to drain over and damage his land. City councillors complained that colleagues had voted on matters that could benefit them financially. Citizens complained about inaccurate and unfair water bills. A woman with a disability complained that her municipality would not waive a fine it gave her for parking in a disabled parking space, even though she had a permit.

Brampton city council recently made a special request to allow the Ombudsman to begin looking into matters in that municipality immediately, in the wake of recent scandals. On May 4, 2015, the council unanimously passed a motion directing the Mayor to ask the province to appoint the Ombudsman to initiate an inquiry under the *Public Inquiries Act* "into the affairs of the Corporation of the City of Brampton, and in particular into potential misconduct in procurement, real estate, planning approvals and any other area." According to media reports in late June, the Ministry of the Attorney General declined this request.

"U" – Universities

Although our Office can and does investigate complaints about Ontario's colleges of applied arts and technology, universities have historically been immune from our scrutiny because of their governance structure. In **2014-2015**, we received a record **72** complaints and inquiries about universities, up **76%** from 41 the previous year.

Students sought our help with such issues as a lack of accommodation for those with disabilities, inappropriate fees, and problems with accessing their records. For example, a student with a disability who could only take half of a part-time course complained that he had to pay full price, and that the university's promise of reimbursement was denied by its financial services department.

"S" – School boards

We received **260** complaints and inquiries about school boards in 2014-2015, by far the highest number to date.

These included concerns about bus service, support for students with disabilities, inadequate consultation about school closure decisions, school board hiring practices, and deteriorating school buildings.

For example, a father complained that his son, who has a disability, had to be pulled out of school because neither parent was able to transport him and the board could not arrange busing for him. Seven families complained about one board that decided to transfer their children to different schools without consulting them, to accommodate a high school changing to a junior high.

Although full Ombudsman oversight of school boards does not begin until September 1, 2015, our Office has had temporary oversight of some school boards in the past, on the rare occasions when the Ministry of Education has taken direct control of them by appointing supervisors. On three occasions between 2005 and 2015, the Ombudsman was able to receive complaints about school boards under supervision: Dufferin-Peel Catholic District School Board (October 2006-August 2007), Toronto Catholic District School Board (June 2008-January 2011), and Windsor-Essex Catholic District School Board (August 2012-November 2013). We responded to these complaints by referring complainants appropriately and raising issues with the supervisors. We initiated a practice of holding regular meetings with supervisors and monitored the boards' progress in responding to concerns and implementing improvements.

"H" – Hospitals – and long-term care homes

Patients, family members, and some staff of Ontario's hospitals approached us with **475** complaints about hospitals and **84** complaints about long-term care homes in 2014-2015.

Hospital complaints included such issues as insufficient communication with patients and families, unsafe conditions, unsatisfactory responses by the hospitals' in-house patient advocates, refusals to release patients from psychiatric care facilities, and unexpected bills for services thought to be covered by the Ontario Health Insurance Plan (OHIP). People who

contacted us about long-term care homes were concerned about their loved ones being pressured to accept unwanted treatment, billing practices, insufficient medical care, and staff conduct. We also received complaints from staff, such as a long-term care worker who was concerned about inadequate infection control.

Although we were unable to investigate these complaints, we referred people to help wherever possible.

Hospitals and long-term care have historically been the area of the MUSH sector that faced the strongest public pressure for Ombudsman oversight. This is in part because they deal with life-and-death matters, they account for large amounts of public spending, and ombudsmen in comparable jurisdictions (e.g., Quebec) oversee them. More private member's bills have called for Ombudsman oversight of hospitals and long-term care than any other areas of the MUSH sector (**10** of the 16 bills referenced hospital oversight; **9** long-term care).

Common complaints about hospitals and long-term care homes over the years have included concerns about poor service, delays, inconsistent application of policies, administrative errors, hiring of medical personnel, quality assurance measures and communications. There remains no independent investigative body to look into these issues, or complaints about in-house hospital patient advocates (sometimes called "ombudsmen").

> "[P]atients may question the independence of [internal hospital complaint mechanisms], given the institution's interest in protecting its own reputation and its close relationship to medical staff... moral suasion from a sufficiently resourced and independent ombudsman or commissioner can positively drive system change."
>
> — COLLEEN FLOOD AND KATHRYN MAY, "HOW TO AVOID A TOOTHLESS TIGER," *CANADIAN MEDICAL ASSOCIATION JOURNAL*, APRIL 2012

Our Office only has authority over hospitals on the rare occasions when the government takes control of them by appointing a supervisor. This has happened about a dozen times since 2005. In these cases, the Ombudsman received a range of complaints, from problems with hospital record-keeping to long emergency room wait times and inadequate infection control. When warranted, our Office held regular telephone meetings with the relevant hospital supervisors to flag significant cases and trends and monitor the response.

In 2008, the Ombudsman launched a systemic investigation into how the Ministry of Health and Long-Term Care monitors inspections of long-term care homes. Although we were not able to investigate the homes themselves, the Ministry committed to numerous improvements that the **Special Ombudsman Response Team** continues to monitor.

As of the writing of this report, no date has been set to establish the Patient Ombudsman created by Bill 8, which will be responsible for handling complaints about hospitals and long-term care homes, as well as Community Care Access Centres. Although the Patient Ombudsman will report to the government and is therefore not fully independent, it is subject to the oversight of our Office, and we will be able to review complaints about it once it is operational.

Children's aid societies

In **2014-2015**, the Ombudsman received **478** complaints and inquiries about children's aid societies (CASs) across Ontario. Concerns were raised about abuse of children in care, failure of CASs to enforce court orders, and lack of reasons given by CASs when apprehending children or keeping them from seeing their parents.

We also received **15** complaints about the Child and Family Services Review Board, some expressing dissatisfaction with its restricted jurisdiction. Although the board oversees CASs, its narrow mandate allows it to consider only procedural concerns about children's aid societies filed by those actually "seeking or receiving services." It is also limited to granting procedural remedies, such as ordering that a CAS respond or provide reasons for a decision.

Early in his first term, the Ombudsman called for the Office's jurisdiction to be expanded to include children's aid societies. At the time, the shocking death of five-year-old Jeffrey Baldwin, who had been placed by a CAS in the care of his abusive grandparents, highlighted the need for oversight of child protection in Ontario. Since then, **seven** of the 16 private member's bills calling for expanded Ombudsman oversight have related to children's aid societies. Two of those went to second reading – further than any other MUSH sector oversight bill, other than the government's Bill 8 – but did not pass.

> "With time, persistence and enough public demand for transparency and accountability, I am confident CASs and other such organizations will eventually have to come into the light."
>
> – OMBUDSMAN ANDRÉ MARIN, ANNUAL REPORT 2007-2008

Ontario remains the only province in Canada whose ombudsman does not have oversight of child protection services. Our Office did have jurisdiction over the Huron-Perth CAS briefly when the province appointed a supervisor to take it over in 2010-2011. As with other MUSH bodies under provincial supervision, we flagged several serious complaints about this CAS to the supervisor and ensured they were resolved.

A few legislative changes have been made since 2005 to bolster oversight of CASs, including the establishment of the Provincial Advocate for Children and Youth as an independent officer of the legislature – like the Ombudsman – in 2007. However, the Advocate's office was not given any investigative authority until Bill 8 was passed in December 2014. As of the writing of this report, the date for the Advocate's new powers to take effect had not yet been proclaimed.

Police

The Ombudsman received **358** complaints and inquiries about police in 2014-2015.

Some of these involved concerns about harassment and abuse by police officers, refusal of police to respond to complaints, inappropriate treatment of people with disabilities, inadequate enforcement of the law, and unsatisfactory responses to complaints about police conduct.

One woman who called police for help because she was suicidal told us half a dozen officers came to her home, treated her roughly, handcuffed her and would not let her get dressed. Another who called police to report abuse by a boyfriend said they urged her not to pursue charges and to let him stay in her home. A man complained that police had put him on a list of "people who bother the police." We refer complaints about police, where appropriate, to the Ministry of the Attorney General's Office of the Independent Police Review Director (OIPRD) or the Special Investigations Unit (SIU).

The OIPRD was created in 2007 by Bill 103, the *Independent Police Review Act, 2007*. It has substantial authority to investigate the conduct of police, but is not independent of government, and is specifically excluded from Ombudsman oversight, unlike the SIU, which only investigates cases where police are involved in serious injuries or deaths. The Ontario Civilian Police Commission is also immune from Ombudsman oversight of its handling of public complaints about police.

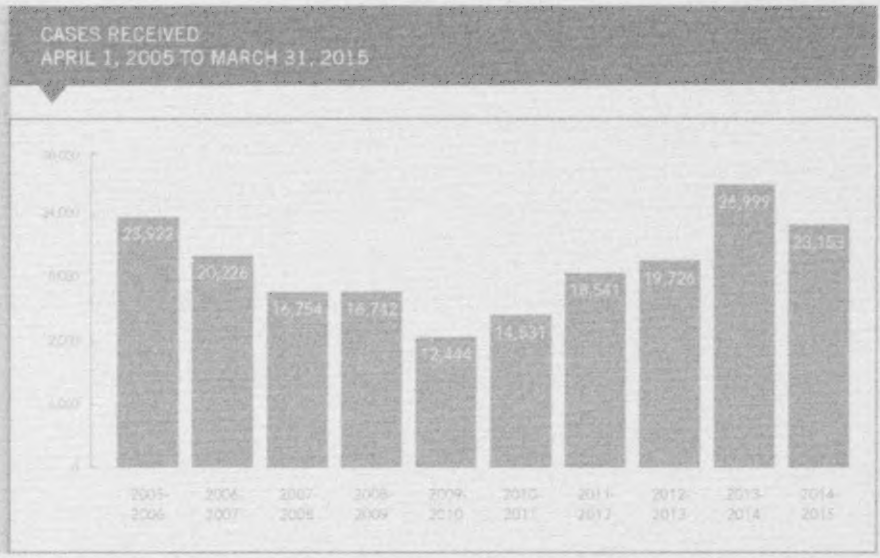
In **2014-2015**, we received **22** complaints and inquiries about the OIPRD, which we had to turn away. People were concerned about the quality of the agency's investigations, that it referred their complaints back to the police organizations they complained about, and that it failed to look into their concerns.

Under Bill 8, the Ombudsman will have jurisdiction over municipalities as of January 1, 2016 – however, the legislation specifically excludes municipal police services boards, meaning no change to oversight of police. Several municipal and police officials, as well as members of the public, have expressed support for Ombudsman oversight of police services boards. The Ombudsman will continue to track complaints about police and revisit this issue in future reports.

Operations Overview: Complaint Trends and Significant Cases

Our Office received **23,153** complaints and inquiries in 2014-2015. Although down from last year's remarkable 26,999 – an unprecedented spike due to the large volume of complaints received about Hydro One – this number is part of a steady increase since 2010. As the accompanying chart of total complaints for the past decade shows, the number dipped in 2009-2010 to 12,444. In that year, the Ombudsman instituted a new digital complaints management system to enable more efficient and accurate tracking of data and trends. He referred to this as the Office's "truth in advertising" initiative in the 2009-2010 Annual Report:

> "There is a story behind the story told in these charts and figures, and it is another chapter in our ongoing work toward reform and transparency. Over the past few years, we have continuously refined our complaints management system to track public concerns as accurately as possible... All public calls are triaged, so the most urgent matters are dealt with immediately, and complex complaints are distinguished from... other basic inquiries... For instance, when a number of inmates at a correctional facility complain to us about the same problem, or submit a petition, this is now counted as one group complaint, as opposed to several dozen individual complaints."
>
> – OMBUDSMAN ANDRÉ MARIN, ANNUAL REPORT 2009-2010



Complaints have climbed **86%** between 2009-2010 and this past year, while our system of triage and early resolution ensured that most (**53.6%**) were resolved within two weeks in 2014-2015, and **46.2%** within one week.

The Operations section of our Office consists of teams of **Early Resolution Officers** and **Investigators**, who focus on resolving individual cases, usually through quick, informal contact with the organization complained about. More complex issues are referred for formal investigation, and some cases and trends are brought to the attention of senior government officials. Senior Ombudsman staff meet regularly with officials from the most complained-about organizations, programs and ministries, proactively alerting them to growing problems and helping to nip them in the bud.

Both teams work closely with the **Special Ombudsman Response Team** (SORT) to identify and resolve potential systemic problems wherever possible. The SORT section of this report outlines our systemic work of the past year, and past decade.

The **Case Summaries** section of this report features examples of the many individual cases that were successfully resolved, helping Ontarians unsnarl themselves from complicated bureaucratic messes and red tape.

The following section outlines key issues and complaint trends addressed by our Operations staff – listed by relevant ministry in alphabetical order.

> "This experience has been one of the most trying times of my life and your support means more than words can justify. Your customer service and dedication has been second to none. [The person who handled my case has] my sincerest gratitude for being a person that I have been able to get assistance and resolution from. Even though they are small steps, they are in the right direction. Thank you so much for everything."
>
> • EMAIL FROM COMPLAINANT

Ministry of the Attorney General

Office of the Public Guardian and Trustee

In 2014-2015, the Ombudsman received **142** complaints about the Office of the Public Guardian and Trustee, which is entrusted to handle the financial affairs of Ontarians who do not have the capacity to do so themselves. Although this is down from **180** complaints last year, the Ombudsman has identified recurring concerns about OPGT staff providing poor customer service and communication to the vulnerable people they serve.

For example, a longtime OPGT client received a payment of almost $33,700 from an insurance company, as reimbursement for 20 years of underpayments. Not only did the OPGT not inform her about the money, it withdrew $15,500 from her account as compensation for being her financial guardian for 13 years. The OPGT is able to collect payment for guardianship if clients are able to pay. However, it can defer payment if a client is unable to pay – a fact that it did not advertise. The woman had repeatedly asked the OPGT for information about her finances and did not receive adequate information about the additional funds or the deferred compensation until our Office intervened. After we drew attention to the issue, it also updated its brochures to better explain the deferred compensation process.

We have also raised concerns about repeated cases where the OPGT has failed to take appropriate action on behalf of its clients to obtain benefits from other government programs. In one case, it did not submit the necessary transportation allowance forms to the Ontario Disability Support Program (ODSP), causing a woman to lose out on that allowance for 14 months. After Ombudsman staff looked into this, the OPGT agreed to reimburse her $1,799.

Senior Ombudsman staff meet quarterly with OPGT officials to discuss complaint trends and serious individual cases. Although the OPGT has been open and responsive to our inquiries, the Ombudsman remains concerned about its customer service problems. Ombudsman staff will continue to monitor complaints and bring forward egregious cases.

Ministry of Community and Social Services

Social Assistance Management System (SAMS)

In November 2014, the Ministry of Community and Social Services launched "SAMS" (Social Assistance Management System), its new computer system for managing cases. SAMS processes all social assistance payments, including those of the Ontario Disability Support Program (ODSP).

Our Office has received numerous complaints from social assistance recipients since the launch of SAMS, including about missing benefits (e.g., shelter allowances or drug and dental benefits), letters erroneously stating benefits were suspended, and Ministry staff failing to return calls. There was a sharp increase in complaints related to ODSP between the SAMS launch on November 11, 2014 and March 31, 2015, compared to the same period the previous year (**328**, up from 245). Complaints relating to ODSP customer service also increased, to **274** from 134.

We inquired with the Ministry and learned some of these problems are directly related to ongoing glitches with SAMS itself, while other issues, such as delays and backlogs, are due to the resulting increased workload. The Ministry acknowledged there have been challenges in implementing SAMS, as well as frustration among staff as they try to navigate the new system while maintaining the same level of service.

The Ministry told us it is addressing these issues, including establishing a working group to prioritize fixing technical issues. At the Minister's direction, the Ministry hired PricewaterhouseCoopers in March 2015 to assess SAMS, suggest short-term fixes for the most urgent problems, and recommend improvements. Its report in May 2015 made 19 recommendations, including a revamped governance structure to assist with the transition to SAMS, and additional training for staff.

Ombudsman staff will continue to monitor issues related to SAMS and meet with Ministry staff for updates. The Ontario Auditor General has also said she plans to audit SAMS, and will release the results in her annual report later this year.

Family Responsibility Office

The Family Responsibility Office (FRO) is responsible for enforcing court-ordered child and spousal support. In 2014-2015, we received **1,167** complaints about the FRO, a slight increase over last year's **1,157** complaints, and considerably more than the 794 complaints received in 2012-2013.

The FRO is consistently among our top sources of complaints – surpassed in the past two years only by complaints about Hydro One, which was the subject of a systemic investigation that drew the highest number of complaints in our Office's history. Common FRO complaints include insufficient enforcement action, inadequate communication with clients and poor customer service.

Our Office works with the FRO to tackle specific cases, and senior staff meet with FRO officials regularly to address broad problems with its services and proactively flag complaint trends.

In one case this past year, a woman complained that the FRO had stopped enforcing her spousal support payments for more than a year. She raised the error several times with her case worker, who denied there was a problem. The woman asked to speak to a manager but didn't receive a call back. We raised the issue with senior FRO staff, and more than seven months after the problem was identified, it finally acknowledged that the case worker had wrongly determined that the woman was no longer entitled to support. By that time, almost $10,000 in spousal support arrears had accumulated.

In response to cases like this, the FRO has acknowledged the need for a "cultural shift" and is working to improve its services, including updating its job descriptions to emphasize the importance of customer service and providing more training for staff. More examples of FRO cases we helped resolve can be found in the **Case Summaries** section of this report.

The Ombudsman has raised concerns in previous Annual Reports about persistent complaints relating to the FRO's Interjurisdictional Support Orders (ISO) Unit, which handles cases where support payors or recipients live outside Ontario. The FRO usually works with enforcement agencies in other jurisdictions to handle support payments in these cases. It recently engaged a consultant to review how it handles interjurisdictional cases and has begun improving the organization of the unit and the management of these cases, including arranging for legal counsel to attend regular staff meetings to consult on specific files. The FRO has also changed the way files are assigned, to eliminate such inefficiencies as having multiple people involved in decision-making. As well, it introduced the new position of "Team Co-ordinator" to provide guidance and advice to FRO staff about file handling.

Uncancelled FRO assignments by ODSP

Last year, the Ombudsman reported the discovery of a serious communication breakdown between the Ontario Disability Support Program (ODSP) and the Family Responsibility Office that resulted in families not receiving thousands of dollars in support payments.

The cases involved people who were entitled to family support payments while they were receiving social assistance, either through ODSP or Ontario Works (OW). Under an arrangement called an "assignment," the FRO sends these people's support payments to the social assistance program. When people are no longer on social assistance, the "assignments" are supposed to be cancelled. But in hundreds of cases, the family support continued to be forwarded to ODSP and held in an account for years. In one case we reviewed, a woman did not receive **$8,000** in child support payments over 14 years because of this error.

In last year's Annual Report, we noted that Ministry staff had identified at least **350** uncancelled assignments and reimbursed more than **$845,000** in retroactive support. Senior Ombudsman staff met regularly with senior Ministry officials on this matter this past year, and the Ministry identified an additional **274** uncancelled assignments requiring reimbursement, to the tune of **$213,651**. The Ministry told us it continues to review these cases and further reimbursements may be required.

The Ministry also plans to upgrade its computer systems so they will automatically cancel assignments when warranted, but this will not happen for about two years. In the meantime, to ensure assignments are cancelled when someone stops receiving social assistance, ODSP has enhanced training for case managers, and the Ministry has developed a system to match ODSP clients with FRO data to identify support recipients who may be owed money. The Ministry is also manually reviewing all current assignment files, and has committed to providing our Office with regular updates as we continue to monitor this issue.

Ministry of Community Safety and Correctional Services

Correctional facilities – complaints from inmates

In 2014-2015, the Ombudsman received **3,904** complaints about correctional facilities, a slight increase from last year's 3,839.

Ombudsman staff triage and prioritize these complaints, focusing on serious health and safety issues, such as correctional staff using excessive force on inmates, inmate-on-inmate assaults, inappropriate and prolonged segregation, and concerns about medical care and treatment. Ombudsman staff encourage inmates to use the facilities' internal complaints processes to address most other concerns.

Toronto South Detention Centre

This new Toronto "superjail," opened in January 2014, was the subject of **422** complaints, including about inadequate health care and sick inmates being housed in segregation cells while all four of the facility's medical units stood empty.

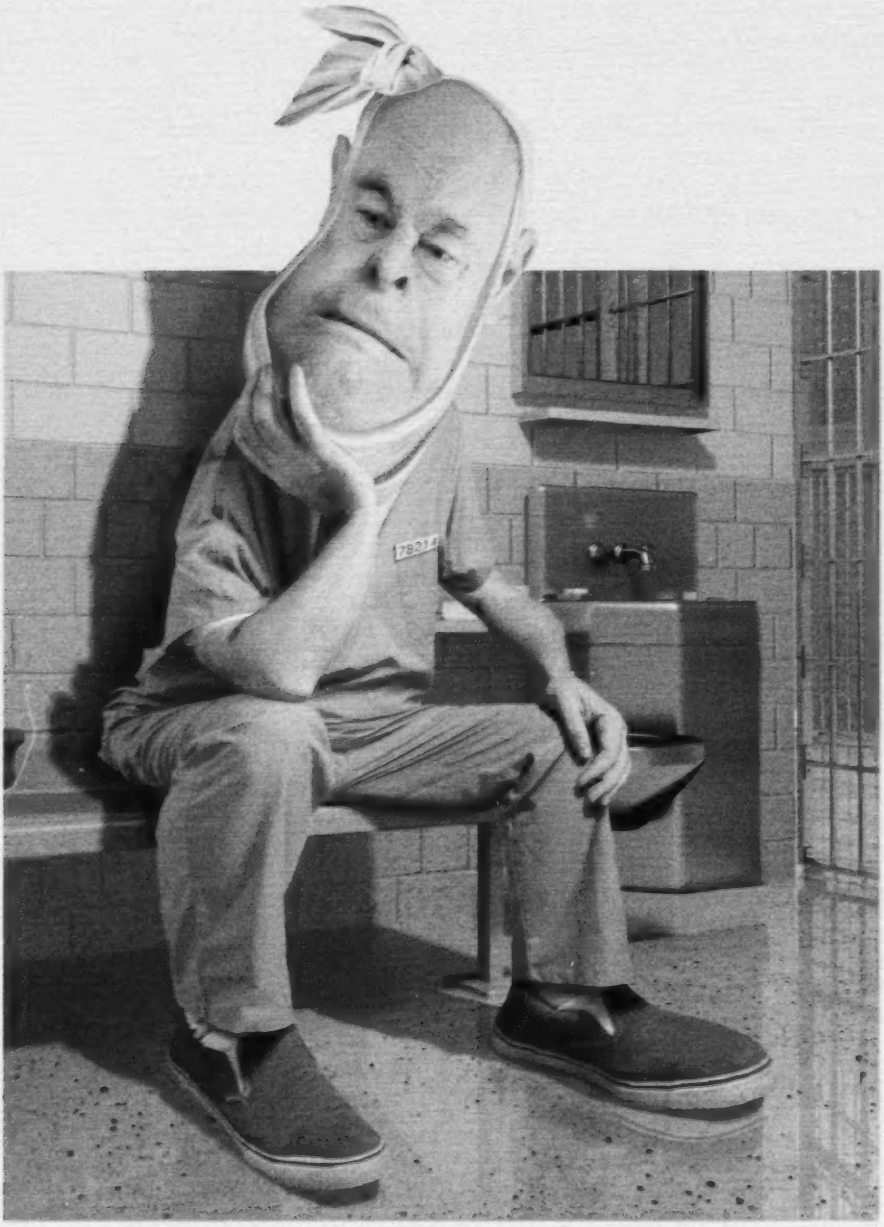
In two especially serious cases, we intervened to ensure that inmates who had undergone major surgery could get to an infirmary to receive proper care. The inmates were in severe pain and had been left in segregation cells without adequate medical services.

> "We've got a shiny new facility but the most important part of it – the infirmary – is not functional. I mean, what's the point?"
>
> – OMBUDSMAN ANDRÉ MARIN, QUOTED IN *TORONTO STAR*, DECEMBER 22, 2014

Senior Ombudsman staff met with Ministry officials in late 2014 to learn why the facility's medical units were not in use, and what the Ministry planned to do about it. The Ministry explained that it had struggled to hire and retain staff, including enough general duty and mental health nurses to provide coverage on its medical units.

By early spring 2015, two medical units had opened: A 30-bed medical housing unit for patients who needed close monitoring was operational in late February, and at the end of March, a 26-bed mental health assessment unit opened after the Ministry closed a separate 40-bed inmate unit to supply the staff. In April 2015, the Ministry was still in the process of hiring specialized medical professionals, including physicians and dental staff.

Also in April, we were told the facility was short on correctional officers, meaning it couldn't open any more units – medical or otherwise. As of the writing of this report, the facility is only able to house 800-860 inmates, just half of its promised capacity of 1,650. The Ombudsman continues to monitor the Ministry's efforts to open its infirmary and a second medical housing unit, and has not ruled out a formal investigation.



Segregation

As noted in last year's report, complaints about segregation, sometimes called "solitary confinement," have been on the rise, and increased sharply over the past year. We received **225** complaints about segregation placements in 2014-2015, up **54%** from 146 complaints the previous year.

Inmate segregation is permitted for a few reasons – for example, for security, as punishment for misconduct, or if an inmate requests it or is in need of protection. Ministry policy requires that "inmates should be placed in the least intrusive or lowest level of security possible," and correctional facilities are required by law to review segregation placements at specific intervals. For a disciplinary placement, segregation must be reviewed after 24 hours, and all segregation placements must be reviewed once every five days. After 30 continuous days, the facility must file a report to the Ministry.

This past year, we saw cases where some inmates were kept in segregation for months at a time without any of the required reviews. Inmates told us the impact of being isolated for 23 hours a day was making them stressed and anxious, even suicidal. At least three segregated Ontario inmates are believed to have taken their own lives.

One facility in Central Ontario couldn't find its records for 60% of segregation placements during certain periods of 2014 - a problem that came to light after our Office requested information about a segregated inmate and noticed that some of the reports we were given included dates when the inmate wasn't in custody. We discovered that a manager had attempted to replicate the missing reports without informing senior officials. In future, the facility will make sure all segregation placements are properly documented, and keep electronic copies of its reports.

Counting the Days: Illustration from Annual Report 2011-2012.

Our staff meet regularly with senior Ministry officials to bring forward the most egregious complaints. The Ministry has addressed the failure of some facilities to adhere to legal requirements by improving monitoring of segregation placements at the Ministry level, and it plans to issue new and clearer reporting forms to facilities later this year.

On March 26, 2015, the Minister of Community Safety and Correctional Services announced a review of segregation policy and how it overlaps with existing mental health policies, including consultation with stakeholders in summer 2015. He said correctional facilities will provide inmates with a guide that sets out segregation procedures and explains inmates' rights. The Ombudsman looks forward to participating in the consultation.

> "While inmates in segregation represent a small percentage of the total inmate population, they often have complex and overlapping needs, which frequently includes mental health issues. We are taking a hard look at our segregation policy to ensure that it is helping those inmates, and aligns with our stated goals of rehabilitation, reintegration, increased mental health supports, and improved staff and inmate safety."
>
> ▶ STATEMENT BY YASIR NAQVI, MINISTER OF COMMUNITY SAFETY AND CORRECTIONAL SERVICES, MARCH 26, 2015

Medical issues

We consistently receive a high number of complaints from inmates about **health care services**, such as a lack of access to medication and medical staff. This year, we received **2,138** complaints about health care issues in correctional facilities, a slight decrease from 2,220 last year.

Complaints involved poor communication between health care staff and physicians, delays in providing services, medication being cut off without a plan for an alternative, and institution doctors refusing to prescribe medications. We also received a significant number of complaints about a lack of services for women with mental health issues, and delays in arranging for inmates with serious mental health issues to see a psychiatrist.

One inmate, a cancer patient in remission who also has multiple sclerosis and a chronic heart condition, told us he was only getting one of the five medications that he was taking before incarceration. After our call, a senior nurse spoke with him and arranged for him to see the doctor immediately to make sure he was receiving the proper medication. Another inmate was vomiting blood and had a leg infection that was getting worse; despite this, he hadn't seen a doctor. After learning the doctor had been prevented from seeing him several times because of lockdowns at the facility, the health care manager arranged for a doctor's visit the same day the inmate contacted our Office.

We also received complaints about the methadone programs in correctional facilities. One inmate reported that he went into opioid withdrawal after missing his daily methadone dose on the day he was transferred to a federal institution. We determined that the provincial facility had decided not to give him the dose and failed to communicate this to the federal institution. As a result of our inquiries, the Ontario facility changed its procedures relating to inmate transfers.

Several inmates at two facilities complained that they didn't receive their methadone doses prior to being taken to court – and experienced withdrawal symptoms during their court appearances. When we intervened, both facilities agreed to look at ways to ensure this did not recur. We continue to monitor this issue.

Use of force by correctional officers

Two years after the Ombudsman's report *The Code*, which looked at the handling of cases of excessive use of force by correctional officers against inmates, we received **79** complaints from inmates about this issue. In such cases, we review the facility's response to ensure the Ministry's reporting and investigation policies are being followed. (For more on our follow-up to the Ombudsman's recommendations in *The Code*, see the **Special Ombudsman Response Team** section of this report.)

One inmate at a correctional facility in northern Ontario complained to us that staff did nothing when he complained about a correctional officer slamming a meal tray hatch on his fingers. Two investigations followed – one by the facility, and another by the Ministry's Correctional Services Oversight and Investigations unit, which conducts investigations into the most egregious matters – and both found that excessive force was used. We monitored the Ministry's response to the findings. It took disciplinary action against staff involved, including those who witnessed the incident and neglected to report what they saw.

Inmate-on-inmate assaults

Inmate-on-inmate assaults are another concern consistently reflected in complaints – **70** this year, 69 last year. The Ombudsman raised this issue in his 2013-2014 Annual Report, citing a case of an inmate who was so badly beaten that he required reconstructive facial surgery. Despite previous direction from the Ministry that all assaults leading to serious injury required an investigation, the assault was never investigated. Since then, the Ministry has changed course, and now takes the stance that correctional facilities are not obligated to conduct formal investigations into inmate-on-inmate assaults, even if an inmate is hospitalized.

In one case we handled this year, an inmate in Eastern Ontario was found slumped over and unresponsive in his cell, with a bite mark on his hand and scrapes all over his face and body. He alleged his cellmate had attacked him and tried to sexually assault him, but said he wasn't sure of the details since he had blacked out. He was taken to hospital for an examination. Due to the Ministry's change of direction, the facility had no obligation to do a formal investigation.

The Ombudsman has raised concerns with the Ministry about serious assaults in correctional facilities going uninvestigated, and we continue to monitor this issue as we await the release of its amended investigations policy, expected later this year.

Transgender inmates

We have received several complaints in recent years alleging discriminatory treatment of transgender inmates – **two** in this past year, and five in 2013-2014. One such complaint, involving a transgender woman who was housed in an all-male facility, was also the subject of a Human Rights Tribunal case, which the Ministry settled in March 2015.

In late 2014, an inmate who identified as female complained to us that she was placed in a male unit, and with a male cellmate, in a Northern Ontario correctional facility for two months. After she alleged her male cellmates had sexually assaulted her, she was confined to a cell on her own, which made her anxious and worried about her mental health. After our intervention, the facility's senior management worked with the Ministry to transfer her to a more suitable facility with a supportive environment. The Ministry also ordered an investigation and found many problems with how this facility and others had housed and dealt with this inmate in the past.

In January 2015, the Ministry released a revised policy on the admission, classification and placement of transgender inmates. Among other changes, it requires that inmates be housed according to their self-identified gender rather than "primary sexual characteristics," and that they be integrated into the general population wherever possible. The Ministry also created a multi-disciplinary team to make placement and care decisions. We will closely monitor the implementation of the policy.

Ministry of Health and Long-Term Care

Primary Health Branch – Northern Health Travel Grant program

The Ministry's Primary Health Care Branch is responsible for directing and managing the Northern Health Travel Grant (NHTG) program, which helps pay for travel-related costs for Northern Ontario residents who must travel at least 100 kilometres one way to access medical specialists and approved health care services at authorized facilities, if not locally available. The NHTG program also provides an accommodation allowance of $100 per trip if the one-way road distance is at least 200 kilometres.

Last year's Annual Report included the story of a woman from Westree who complained to us that she was denied the accommodation allowance in late 2011 when she had to travel for a colonoscopy: The destination, Sudbury, was 193 kilometres from her home, just seven kilometres short of the required 200. We raised concerns with the Ministry about the need for more flexibility in such cases. After two years of discussion and review, the Ministry established the NHTG Medical Appeals Committee, an internal appeal process to deal with exceptional circumstances. The committee will review applications where there are extenuating medical circumstances and make recommendations on granting exceptions to the eligibility criteria. The committee reviewed the woman's case and she was finally granted her $100 allowance in July 2014.

As of March 2015, the Ministry's website and NHTG program brochures were updated to provide the public with information about the new appeal process.

In another case we received that was reviewed by the committee, a man from Timmins was denied funding to travel to Toronto for injections of a drug to treat chronic asthma – because the drug was not administered at a Ministry-approved health care facility. However, the drug's manufacturer had specifically hired the Toronto clinic to prepare the drug and monitor the patients according to strict specifications. The committee ultimately recognized the special circumstances and the man was reimbursed for his travel costs of nearly $6,000.

Community Care Access Centres

Community Care Access Centres (CCACs) co-ordinate support services for people living at home who require nursing, physiotherapy or occupational therapy services, or assistance with personal care, such as bathing, dressing and eating. There are 14 CCACs across Ontario, which will be removed from our Office's jurisdiction once the Patient Ombudsman established by Bill 8 is in place (as of the writing of this report, no date for this has been set).

In 2014-2015, we received **128** complaints about CCACs. Most were about the number of hours of service offered and the quality of the services provided, as well as delays in providing services and waiting lists for long-term care. Our Office received excellent co-operation from CCACs across the province when we inquired about individual cases.

For example, we contacted one CCAC on behalf of a woman whose severely disabled 20-year-old son required physiotherapy, nursing and assistance with personal care. His mother, who was his primary caregiver, also had significant health problems and had been waiting more than six months for the CCAC to assess her son's needs. After speaking with our Office, the CCAC acknowledged that it hadn't provided adequate customer service and subsequently arranged physiotherapy for her son.

We also intervened to help an 80-year-old woman access CCAC support to care for her terminally ill son, who was being discharged from hospital to live with her. She was initially told by the CCAC that it could not provide the assistance with bathing and personal care that he needed, but after we contacted the CCAC, it agreed to provide four hours per day of personal care and nursing support for the son's medication needs.

Ministry of Natural Resources and Forestry

Aggregate business designations

Ontario's *Aggregate Resources Act* controls and regulates the use of aggregates, such as gravel, sand, clay, earth, and stone, which are mainly used in construction projects like roads, homes and subway tunnels. Under the Act, aggregate business operators in designated geographic areas are subject to a system of licensing, monitoring, inspection and enforcement, and annual licensing fees and costs.

In last year's Annual Report, the Ombudsman highlighted a case where one licensed aggregate operator from a designated area complained that it was unfair not to subject all aggregate producers to the same rules. He complained that operators in designated areas are at a competitive disadvantage when bidding for contracts against unlicensed operators from neighbouring non-designated areas, because unlicensed operators are not subject to the same licensing costs and requirements.

In February 2014, the Ministry announced stakeholder and public consultations on changes to the *Aggregate Resources Act*. Ministry officials confirmed in March 2015 that this process was now complete and the issue of designation was discussed. The Ombudsman will continue to monitor this issue as the Ministry reviews and develops policy and regulatory changes based on the consultations.

Ministry of Training, Colleges and Universities

We received **615** complaints relating to this ministry in 2014-2015. Some **274** were about private career colleges, while **110** involved colleges of applied arts and technology. We also received **156** complaints about the Ontario Student Assistance Program. Common complaints about colleges of applied arts and technology involved communication issues and the quality of programs, as well as disagreements with staff decisions on such things as grades and tuition.

Private Career Colleges Branch

The Ministry's Private Career Colleges Branch regulates private career colleges, enforcing legislation if they operate without being registered or otherwise break the rules.

The **274** complaints we received about this branch represent an enormous increase from last year's total of just 15. Almost all of this influx was related to the abrupt closure of Everest College and its 14 campuses, comprising nearly 2,700 students. We received **261** complaints about the closure of Everest – 130 of them in a single day.

On February 19, 2015, the branch suspended Everest's registration after it learned the institution was likely to enter into insolvency proceedings and students wouldn't be able to complete their programs. Everest declared bankruptcy the next day and on March 13, its registration was permanently revoked. It was the branch's responsibility to help students find other colleges to finish their courses, or to provide partial refunds for Everest tuition through the Training Completion Assurance Fund.

"These are students who don't necessarily have much of a bright future – whether they are single moms, or …some of them are on social assistance … [they] are really in dire straits and they are going through school trying to get a better life. These are amazing young women, and all of a sudden the carpet was pulled out from beneath them."

► FORMER EVEREST COLLEGE INSTRUCTOR, QUOTED IN THE *TORONTO STAR*, MARCH 11, 2015

The Ombudsman set up a dedicated team of staff to deal with the high volume of complaints, and senior staff from our Office met weekly with officials from the branch and Ministry for updates on its efforts to help students. We also worked with senior Ministry officials to resolve urgent cases and facilitate communication between students and the Ministry. The Ministry was responsive and co-operative with our inquiries, due in large part to the proactive efforts of the Assistant Deputy Minister.

The closure of Everest College had significant emotional and financial impact on hundreds of students and their families, but the branch was initially overwhelmed and unprepared for the volume of inquiries it received. We received numerous complaints from students that the branch failed to help them, provided poor communication and delayed in providing them with options for other schools. Many were dissatisfied about the options they were given as well.

Some students had difficulty accessing Ontario Works funding or did not receive their Ontario Student Assistance Program installments, including living allowances. Others who wanted to work in the interim were stymied, uncertain of when they could resume their studies at a new school. Many were concerned that their delayed graduation meant they would have to wait longer to accept a job, or to write professional exams that are only offered at certain times of year. Some were also faced with losing daycare spots for their children, since their municipal or provincial funding required them to be enrolled in classes.

One Everest student who only had 36 hours of a placement left to complete prior to graduation, and had already paid to write a professional exam in a few months, complained that she tried for a month to speak with someone at the Ministry, to no avail. The Ministry promptly provided her with information after we intervened, but made several mistakes – it misidentified her program and sent a list of alternative course options to the wrong email address. We intervened again, and the student received the correct options package.

Another Everest student complained to us that the Ministry told her she would have to pay $4,414 in outstanding tuition to finish her program elsewhere. We reviewed her tuition receipts and bank statements, as well as the Ministry's calculations, with senior Ministry staff, who agreed she had not been properly credited for previous payments and did not owe any money.

In addition, 88 complaints related to the 450 employees who lost their jobs when Everest closed. We referred them to help with employment standards and provided information about where to get answers regarding unpaid severance and other entitlements.

The Ombudsman continues to monitor the Ministry's response to complaints relating to Everest College and will be following up to review how its response can be improved in such situations in future.

Ministry of Transportation

In 2014-2015, we received **566** complaints about the Ministry of Transportation, up from 525 last year. Many of these were about the Ministry suspending drivers' licences inappropriately, refusing to reinstate licences, or its fees or conditions for licence reinstatement. Quarterly meetings between senior Ombudsman and Ministry officials have proactively resolved many individual and potential systemic issues.

Medical Review Section

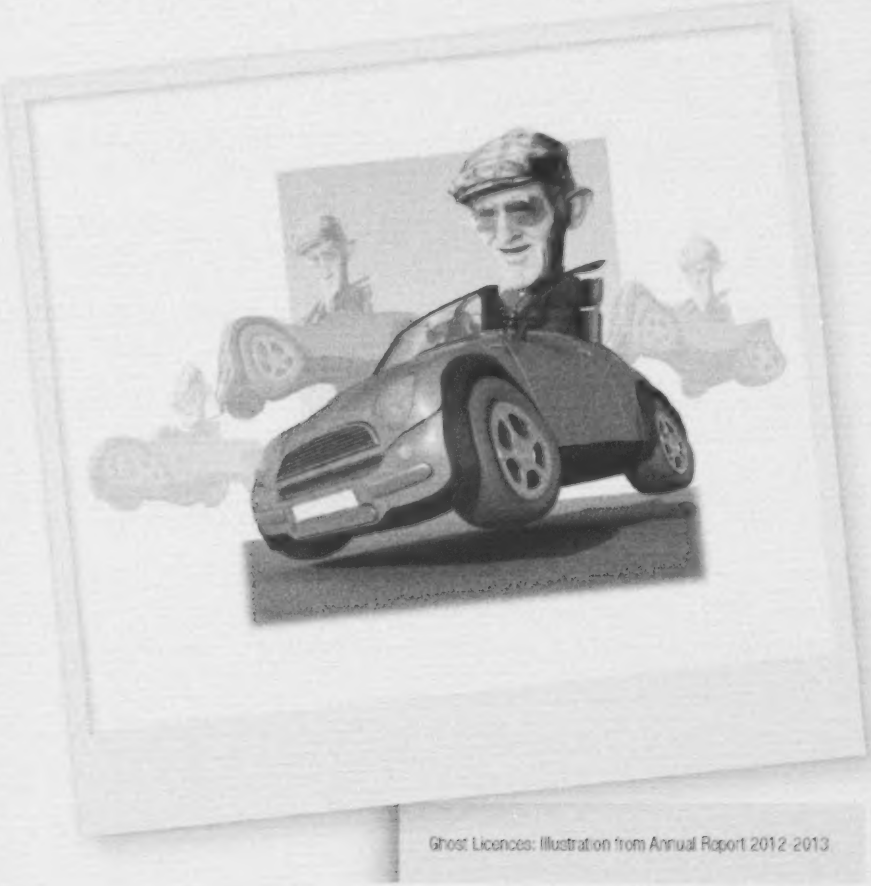
This year, we noticed a significant increase in complaints about the Ministry's Medical Review Section, which suspends drivers who are unfit to drive due to medical reasons – **243** complaints, up from 141 the previous year. For many people, a driver's licence is a necessity for their work. Many complained that the Ministry was slow to reinstate licences even after it had the necessary paperwork, such as updated medical information.

One man, who was required to drive to his workplace, was at risk of losing his job after waiting more than two months for the Ministry to review medical information confirming he was fit to drive. It was only after our Office contacted the Ministry that it reviewed the man's file and agreed to reinstate his licence.

In a similar case, another man had heard nothing from the Ministry two months after sending in a medical report from his doctor attesting to his ability to drive. He contacted the Ministry and was told more information was required. Even though his doctor sent the information that day, he was told it would not be reviewed for 50 more business days. Our Office persuaded the Ministry to review his file and reinstate his licence right away.

Licensing Service Branch – "Ghost licences" update

In 2011-2012, the Ombudsman first reported on a public safety issue involving the Ministry's practice of creating "master" licence records in its computer system. A "master" record is created and used as a placeholder in the Ministry's database to store information about a driver for whom no existing licence can be found. When the Ministry eventually creates or finds the driver's official licence record in its database, the information from the master is transferred and the duplicate record is supposed to be eliminated.



Ghost Licences: Illustration from Annual Report 2012-2013

However, if there is an error in the information used to create the master record (such as a spelling error in the driver's name), then it will likely remain in the Ministry's database even if the Ministry has found or created the driver's official record, because the information won't match, and the current computer system isn't able to detect duplicate records when they contain small variations in spelling or addresses. The result is what the Ombudsman referred to as "ghost" licences in the system.

The Ombudsman discovered this issue due to a case in 2011-2012, where a convicted drunk driver was able to continue using his official licence for several years because his drunk driving conviction was added instead to a "master" record that misspelled his last name. This duplicate record remained in the Ministry's system until police identified the error seven years later.

Our Office has worked closely with the Ministry on the issue for the past four years. The Ministry confirmed it had more than **1.1 million** "master" records in its database, **235,000** of which related to individuals living in Ontario (the rest were created to store information about out-of-province drivers). Of those, 552 were for drivers who had been flagged for suspension; 99 related to "high-risk" drivers (suspended for criminal offences), and 274 to "medium-risk" drivers (suspended for medical reasons).

This past year, the Ministry told us it found an additional **85** "master" records, of which **nine** were for high-risk drivers and **47** for medium-risk drivers. All were contacted and notified that they should not be driving. The Ministry plans to continue manually searching its database for any remaining duplicate records and advising drivers who should be suspended.

It has also begun implementing measures recommended in a March 2014 report from the Ministry of Finance's Internal Audit Division, which audited the licensing control system. For example, it is developing a standard format for records to improve accuracy, and increased its outreach to stakeholders who provide information about drivers – e.g., physicians, courts and police – to raise awareness about the impact of incomplete or incorrect reports. The Ministry now conducts regular reviews of newly created master records to find possible duplication, and is looking at ways to improve record merging and matching.

We continue to receive regular updates about this issue and the Ministry's progress in implementing recommendations from the audit.

Licence suspension letters

The Ombudsman reported last year on the case of a woman whose driver's licence was cancelled by the Ministry in 2010 because she failed to pay a $150 reinstatement fee. The woman complained that she had no idea that the licence would be cancelled, because the fee requirement was written in small print on the back of her temporary licence suspension notice. She said she had continued to use her cancelled licence for three years without incident, despite being stopped by police and going to court for driving infractions. She ultimately had to undergo the licensing process all over again, including a driving test.

After we brought this to the Ministry's attention, it revised its licence suspension and reinstatement notice. The new "Notice of Outstanding Licensing Requirements," released in March 2015, clearly explains that if the $150 reinstatement fee is not paid immediately at a ServiceOntario centre, the driver's licence will not be reinstated.

Administrative tribunals

Our Office consistently receives hundreds of complaints every year about Ontario's administrative tribunals, the independent, quasi-judicial bodies that make decisions about such things as benefit entitlements, licences, disputes between citizens, or disputes citizens have with the province. In 2014-2105, we received **1,182** complaints about administrative tribunals, whose powers and scope have increased in recent years.

Given their impact on individuals' lives as well as public services, it is important that administrative tribunals have adequate oversight to ensure they act fairly and within their statutory mandate. Although the Ombudsman cannot overturn tribunal decisions, our Office does have the power to review their decisions and processes and make recommendations. From our unique vantage point and experience in reviewing decisions across the spectrum of tribunals, we can also spot trends and flag issues to the government.

A key issue we are monitoring is the impact of the government's "10-year rule" – a cabinet directive from 2006 that appointments to regulatory or adjudicative agencies such as tribunals should be limited to 10 years. This raises concerns that many long-term tribunal members may not be reappointed as of 2016, with the potential for shortages in members on some tribunals and an overall decrease in the number of tribunal members with valuable experience.

The Society of Ontario Adjudicators and Regulators recently released a study on the impact of the rule, which warned that tribunals might be unable to fulfill their statutory mandates. Citing the examples of the Workplace Safety and Insurance Appeals Tribunal and the Ontario Labour Relations Board, it stated: "The loss of half of their adjudicators means that the average level of experience will decline from approximately 10 years to approximately three. This means that half of their adjudicators will have no experience with that tribunal." The Ombudsman has expressed serious concerns to the government about the need for careful planning to mitigate the impact of this rule on administrative tribunals and their operations. Our Office will monitor developments closely.

Ministry of Labour – Landlord and Tenant Board

We received **95** complaints about the Landlord and Tenant Board (LTB) this year. Although this is fewer than the 138 and 139 complaints received in the previous two years, the board remains among our top three most complained-about tribunals. Many of the complaints were about poor communication from the board, which left people confused and frustrated about its processes. As in previous years, Ombudsman staff emphasized that the board needs to better train its staff and adjudicators.

In one case, a landlord and a tenant met with an LTB mediator and reached an agreement: The tenant was to move out and pay the landlord a certain amount of money by a certain date. However, the order issued by the LTB left out the payment date, and the landlord was worried the tenant would not pay. The LTB took the position that it had no obligation to include the date in the order and refused to amend it. Ombudsman staff raised concerns with the LTB that its mediator didn't fully explain the process to the parties, and it agreed to emphasize the need for clarity in its mediator training sessions.

Another tenant contacted us in January 2015 in frustration over conflicting information she received about an application she made in an LTB hearing in June 2014. In August 2014, she was told her matter was still under consideration. In November 2014, she was told that it had been dealt with. When she asked for a recording of the hearing, first she was told she could have it if she paid a fee; then she was told no recording existed. Our Office determined that a disc of recordings from the woman's hearing date existed, but her hearing was not actually recorded. Her fee for the recording was refunded, and the LTB agreed to review her application, acknowledging that it had never been addressed.

Long Wait: Illustration from Annual Report 2012-2013.

Ministry of Labour – Workplace Safety and Insurance Appeals Tribunal

We received **99** complaints about the Workplace Safety and Insurance Appeals Tribunal (WSIAT) in 2014-2015, almost all of them about delays. The tribunal hears appeals from injured workers, most of whom have already spent years waiting for their claims to be adjudicated by the Workplace Safety and Insurance Board (WSIB). If they are dissatisfied with the board's decision, they can appeal to the tribunal – but most will not be heard for two or more years.

Many of the complainants we heard from were under great financial duress and extremely anxious about the impact of these delays. One woman said she and her family were at risk of becoming homeless as they waited for a decision on her entitlement to benefits. A middle-aged man said he had lost his home and moved in with his parents.

In looking into the cause of the delays, we determined that appeals from the WSIB had doubled in recent years, while the number of adjudicators for hearing appeals had been reduced. Senior Ombudsman staff met with WSIAT's chair, representatives of the Ministry of Labour, and other government representatives to remind them of the human impact of these delays and urge them to work together to find a solution. The Ombudsman is monitoring the situation and the Ministry's response to it, to assess whether a systemic investigation is warranted.

Systemic Investigations: Special Ombudsman Response Team (SORT)

The Ombudsman created SORT in 2005 to make the most efficient use of the Office's resources in tackling broad, systemic issues affecting large numbers of people. The team is a dedicated group of investigators, supplemented by other staff as warranted, that tackles complex cases involving extensive amounts of field work, research, interviews and document review.

SORT investigations typically result in stand-alone reports and recommendations aimed at achieving bureaucratic reforms. The Ombudsman's recommendations arising from these investigations have been overwhelmingly accepted and implemented by the government. Ombudsman staff routinely follow up on all SORT cases to track the progress of recommendations and to ensure problems don't recur. In cases involving large volumes of complaints, Early Resolution staff and Investigators work alongside SORT staff to ensure individual cases are handled quickly while the systemic issues are reviewed.

The SORT investigation model, including techniques for identifying issues, planning investigations, conducting interviews, assessing evidence and writing and disseminating reports and recommendations, also forms the basis for the Ombudsman's globally recognized training course for ombudsmen and administrative watchdogs, "Sharpening Your Teeth." More on this can be found in the **Training and Consultation** section of this report.

Investigations completed in 2014-2015

In the Dark – Hydro One – Ministry of Energy

The largest investigation in the history of the Ombudsman's Office, this case drew nearly **11,000** complaints, culminating in the release of the report *In the Dark* in May 2015. The Ombudsman announced his investigation into Hydro One's customer service and billing problems in February 2014 in the wake of a sharp increase in complaints dating back to May 2013 – when the utility introduced a new, $180-million customer information system.

The investigation revealed that problems with the system transition resulted in a massive disruption of billing, including overbilling (sometimes by thousands or even millions of dollars), no bills, prolonged estimated bills, and egregious customer service. But as the crisis worsened, the utility worked to downplay the situation, including to its board of directors, the electricity system regulator, the Ministry and our Office. Ultimately, it cost Hydro One $88.3 million to fix the problems, which the Ombudsman estimated affected well over 100,000 customers.

The Ombudsman noted that Hydro One's inward-facing and overly technocratic culture caused it to lose sight of its duty to the public – including pressuring the private contractor that runs its outsourced call centre to keep call handling times down, further frustrating customers.

May 25, 2015: Ombudsman André Marin releases *In the Dark*, his report on billing and customer service problems at Hydro One.

> "When the technical problems sparked a flurry of erroneous bills and a flood of calls from frustrated customers, Hydro One reacted in the worst way possible – with deflection and deception. It minimized the issue, misled its overseers, relied on public relations spin and put its customers last."
>
> – OMBUDSMAN ANDRÉ MARIN, AT PRESS CONFERENCE RELEASING *IN THE DARK*, MAY 25, 2015

He also issued an update on the investigation in March 2015 to highlight Hydro One's disturbing and deceptive practice of threatening to disconnect customers for unpaid bills in winter, despite its policy never to do so.

To handle the unprecedented volume of complaints, our Office took a two-pronged approach, with SORT staff focusing on the systemic investigation while individual cases were handled by a dedicated team of staff who flagged them to a corresponding team at Hydro One – quickly resolving more than **4,100** in the process (examples of some of these cases can be found in the **Case Summaries** section of this report).

The systemic investigation involved more than **190** interviews with current and past Hydro One executives, frontline staff, stakeholders, and the utility's outsourced agencies, as well as whistleblowers and staff from the Ontario Energy Board and the Independent Electricity System Operator. The team also reviewed tens of thousands of Hydro One internal documents and more than 150,000 emails.

> "Hydro One is Ontario's problem. But the findings of the Ombudsman echo and resonate in every province. Customers of the Internet service providers, telephone companies, banks, any largescale company or public utilities in any province or territory, will have fables of equal strength, if not equal horror, to that unveiled here in the corporate heartland this week."
>
> ▶ REX MURPHY, *NATIONAL POST*, MAY 30, 2015

The Ombudsman made **65** recommendations to Hydro One, all of which it accepted. These included:

- Adopting a proactive, transparent and accountable approach to communicating with its stakeholders – including oversight and regulatory bodies;
- Ensuring customer service staff have sufficient and consistent training;
- Arranging random independent audits of how customers are dealt with, and taking customer feedback into account;
- Planning projects much more thoroughly, including risk assessment reviews;
- Refunding customers promptly for inaccurate bills; and
- Making bills simpler to understand and the customer complaint process easier to navigate.

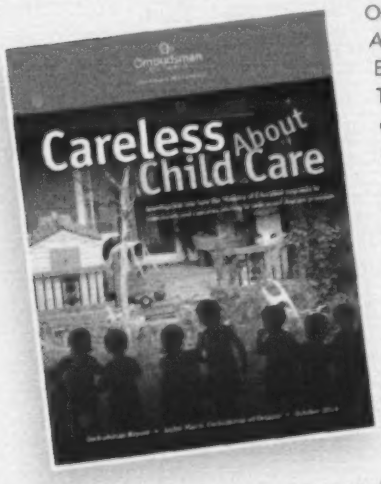
The Ombudsman also recommended that the government reconsider its plan, included in its 2015 budget bill – Bill 91, the *Building Ontario Up Act (Budget Measures), 2015* – to remove independent oversight from Hydro One as part of its plans to partially privatize the utility. This recommendation echoed an historic joint statement by eight officers of the Legislature, issued on May 14, 2015, urging the government to reverse its plan to remove it from oversight of the Ombudsman, Auditor General, Information and Privacy Commissioner, Financial Accountability Officer, Integrity Commissioner and French Language Services Commissioner, given that the government is still expected to retain the largest share of Hydro One under the privatization plan.

> "The Officers are concerned that while the government intends to eventually hold 40% of Hydro One over the long term, their ability to assess its value and quality of service, among other matters, would be eliminated... The government would take the revenue from its Hydro One stake and reflect it in its consolidated revenues, and yet Ontarians would receive no operational information on Hydro One from Ontario's independent Legislative Officers."
>
> ▶ STATEMENT SIGNED BY OMBUDSMAN, AUDITOR GENERAL, INFORMATION AND PRIVACY COMMISSIONER, FINANCIAL ACCOUNTABILITY OFFICER, INTEGRITY COMMISSIONER, ENVIRONMENTAL COMMISSIONER, PROVINCIAL ADVOCATE FOR CHILDREN AND YOUTH AND FRENCH LANGUAGE SERVICES COMMISSIONER, MAY 14, 2015

On May 21, 2015, the Ombudsman and the Auditor General also made a joint submission to the Standing Committee on Finance and Economic Affairs during its hearings on the budget bill, again urging that Hydro One remain subject to independent oversight.

However, Bill 91 was passed and given royal assent on June 4, 2015. Under the legislation, the Ombudsman can no longer accept any new complaints about Hydro One, but has six months from June 4, 2015 to complete any ongoing investigations. The Ombudsman has notified Hydro One and its subsidiaries of **578** complaints that were ongoing as of that date. Our dedicated team of staff is working closely with Hydro One to ensure that all of these cases can be resolved before the deadline. Under the new legislation, Hydro One must also appoint an internal ombudsman to handle public complaints; however, as of the writing of this report, there was no indication as to when this new position would be filled.

Careless About Child Care – Ministry of Education



On October 22, 2014, the Ombudsman released *Careless About Child Care*, his report on how the Ministry of Education deals with complaints about unlicensed daycares. The investigation was launched in July 2013, after the death of two-year-old Eva Ravikovich amid overcrowded and unsanitary conditions at what the Ombudsman called a "brazenly illegal" home daycare near Toronto. Four children died in unlicensed daycares in the Greater Toronto Area alone in 2013-2014.

> "To the Ministry's credit, the shock of Eva's death and this investigation sparked long overdue improvements. All this makes me hopeful that lessons have been learned from the tragedies covered in our report."
>
> – OMBUDSMAN ANDRÉ MARIN, STATEMENT REGARDING THE RELEASE OF *CARELESS ABOUT CHILD CARE*, OCTOBER 22, 2014

The investigation revealed what the Ombudsman called a "legacy of dysfunction" that was compounded when the Ministry of Education took over the oversight of daycares from the Ministry of Children and Youth Services in 2012. However, he noted that the inadequacies of the outdated *Day Nurseries Act* had been known for years, and the momentum for legislative reform had been slow. Among the systemic problems identified were:

- Sloppy, inconsistent complaint intake practices and an inadequate complaint tracking system;
- Ministry guidelines not followed, inspections delayed or never done;
- Staff untrained in conducting investigations or on the legislation they enforce;
- Poor inspection practices, careless evidence gathering;
- Failure to involve or educate parents about daycare standards and facilities that are not in compliance with them; and
- Legal loopholes allowing illegal daycares and operators who are repeat violators to do business with impunity as "private schools" or "camps."

The Ombudsman issued an unprecedented **113** recommendations, aimed at improving the Ministry's investigation of complaints about unlicensed daycares and its enforcement of the outdated legislation. These included the establishment of an enforcement team for investigating complaints, adequate resources to ensure effective and timely enforcement, better training and case management tools, and involving parents in the enforcement process, where appropriate.

Although he did not recommend that all daycares be licensed, or that unlicensed daycares be limited to a specific number of children, the Ombudsman did recommend the Ministry consider the feasibility of a centralized registry and tougher standards for all unlicensed daycares.

> "I welcome the Ombudsman's recommendations regarding the unlicensed child care sector and how we can improve our system. I am pleased to confirm that over 95 of the report's 113 recommendations are already being addressed and that work is underway, or planned, for the Ombudsman's remaining recommendations."
>
> ▶ STATEMENT BY EDUCATION MINISTER LIZ SANDALS, OCTOBER 22, 2014

The Ministry accepted all of the recommendations in a spirit the Ombudsman described as "genuine and focused."

Most significantly, the new *Child Care Modernization Act* was passed and given royal assent in December 2014, replacing the *Day Nurseries Act*. The new law addresses 35 of the Ombudsman's recommendations, including increasing fines for illegal operations and empowering inspectors to close them immediately when warranted. It also imposes a new government policy restricting the number of children allowed in an unlicensed daycare to five, including the operator's own children. The Ombudsman's report did not recommend such a cap, but noted that under the previous legislation, Ontario's rules on unlicensed daycare capacity were among the most lax in Canada.

The Ministry provided its first six-month progress report to the Ombudsman in April 2015, noting that 55 of the recommendations were "completed," while most of the remainder would be dealt with as the new legislation and its accompanying regulations were implemented.

The significant changes the Ministry has already made include:

- Establishment of a dedicated enforcement unit to handle complaints about unlicensed daycares;
- A toll-free phone number for complaints about unlicensed daycares;
- A searchable online registry that allows the public to access information about violations and convictions of unlicensed daycare operators; and
- Updated information on its website for parents seeking child care options.

The Ministry has indicated that it expects to make two further reports to the Ombudsman on the implementation of his recommendations over the next 12 months.

> "There's no question that Marin's report, and the government's action on it, should lead to safer unregulated daycare in the province. And that is welcome news."
>
> ▶ EDITORIAL, *TORONTO STAR*, OCTOBER 27, 2014

Ongoing investigations

De-escalation direction to police – Ministry of Community Safety and Correctional Services

The Ombudsman launched this investigation in August 2013, shortly after 18-year-old Sammy Yatim was shot dead by Toronto Police, who had him surrounded on a streetcar, alone and holding a small knife. It focused on the training and direction that the Ministry provides to police on the use of force and techniques for de-escalating similar situations.

The investigation drew **176** complaints from concerned citizens, members of the law enforcement community, and interest groups. SORT investigators conducted **95** interviews, including with personnel at the Ontario Police College, academics, psychiatrists and psychologists with experience in policing and crisis resolution, retired chiefs of police, and family members of several people who were killed in interactions with police. As well, the Ombudsman invited input from police services and police associations across the province, and took the unprecedented step of appointing two respected former chiefs as special advisors to the investigation.

The Ombudsman's preliminary report and recommendations have been drafted and the Ministry has been given the opportunity to respond. The final report will be released in the coming months.

Adults with developmental disabilities in crisis – Ministry of Community and Social Services

Launched in November 2012, this investigation stemmed from a surge in complaints to our Office about urgent, disturbing cases where adults with severe special needs were ending up in jail, homeless shelters and hospitals, because no care or services were available for them. Focused on whether the Ministry is doing enough to assist adults with developmental disabilities who are in crisis situations, this is the Ombudsman's most complex investigation to date. As of the writing of this report, it has drawn more than **1,300** complaints, and more than **200** interviews have been conducted by SORT investigators.

Given the high volume of complaints, the pressing needs of the families involved and the complicated nature of the problem, we have taken a two-pronged approach to this case: While SORT staff probed the underlying systemic issues, a dedicated team of Investigators and Early Resolution Officers helped – and continues to help – people in crisis resolve their particular situation wherever possible.

Systemic investigation: The field work in this case has been completed and the Ombudsman's report is being drafted. As is our normal process, the Ministry will be given a chance to respond to the Ombudsman's findings before he releases them publicly later this year.

As the investigation has progressed, the Ombudsman has monitored government efforts to address problems in this area. Recent developments include:

- February 2014: Minister announces Developmental Services Housing Task Force to look for innovative, cost-effective housing solutions for adults with developmental disabilities.
- April 2014: Government promises to add $810 million over three years to programs and services for adults with developmental disabilities.
- July 2014: Select Committee on Developmental Services, made up of MPPs from all parties, issues 46 recommendations, including the elimination of waiting lists and the co-ordination of services.

Individual cases: We heard from several families this past year who were able to receive increased funding through the "Passport" program, which provides for programming for people with developmental disabilities as well as respite for their caregivers. However, parents continued to come to us in frustration over a lack of home support for their adult children who are living on their own, but still require assistance and care.

Ombudsman staff encountered many Ministry-funded service provider agencies that were uninformed about or unfamiliar with the workings of important government programs that interact with the people they serve. We handled several cases where these agencies communicated inadequate or wrong information to clients about everything from the Ontario Disability Support Program to the criminal justice system. We also noticed that Ministry staff did not closely monitor agencies to ensure they follow its procedures, including those designed to help people in urgent circumstances.

In one case, a young man with a developmental disability had been criminally charged and released on bail on a condition that his father supervise him 24 hours a day. When his father was unexpectedly hospitalized, he was returned to jail. We discovered that the service agency did not understand the man's bail conditions and did not notify his lawyer that the father was in hospital, putting him at risk of incarceration. Ombudsman staff intervened, and with the assistance of the Ministry, the young man was moved to an appropriate residential living arrangement where he could be supervised full-time.

We continue to receive complaints from families of adults with developmental disabilities who have been placed in hospitals or psychiatric units while they wait for an appropriate residential placement – sometimes for weeks or even years. Many have languished in hospital rooms for long periods with no programming or other supports.

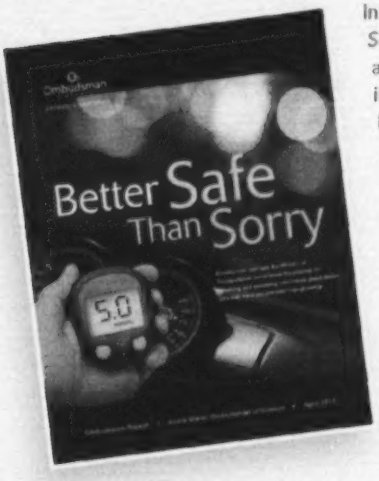
For example, we reviewed one case of a 33-year-old man who lived in a hospital for seven years after being admitted due to aggressive behaviour. He required support in completing self-care tasks but had no medical needs that required him to be hospitalized. We also looked into the case of a 40-year-old man who lived in the psychiatric unit of a hospital for more than five years after he exhibited aggressive behaviour towards his elderly parents.

Our office has worked closely with the Assistant Deputy Minister, Community and Developmental Services, who has been instrumental in finding placements for many of these individuals. To date, **17** people whose cases we brought to the Ministry's attention have been discharged from hospital to appropriate residential placements.

In Crisis: Illustration from Annual Report 2012-2013.

Updates on previous investigations

Better Safe Than Sorry – Ministry of Transportation – Monitoring of drivers with uncontrolled hypoglycemia



In April 2014, the Ombudsman released *Better Safe Than Sorry*, his report on how the Ministry of Transportation administers the process for obtaining and assessing information about drivers who may have uncontrolled hypoglycemia.

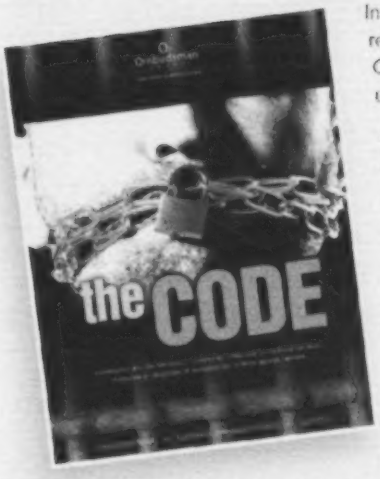
The Ombudsman launched the investigation in March 2012 as a result of a catastrophic motor vehicle accident caused by a driver experiencing uncontrolled hypoglycemia, in which three people were killed. Although the accident occurred in June 2009, the Ministry did not suspend the driver's licence until January 2011. In December 2011, the driver was convicted of dangerous driving causing death.

The Ombudsman's report uncovered inconsistencies, errors and bureaucratic failures in the province's system for reporting and monitoring drivers with potentially dangerous medical conditions. He made **19** recommendations, focused on improved training for staff, enhanced medical forms which are easier to understand and elicit more detailed information from drivers and physicians, easier access to information by way of revisions to the relevant sections on the Ministry website, and more education and outreach.

The Ministry accepted all of the Ombudsman's recommendations and committed to update the Ombudsman every six months on their implementation. It has implemented **12** out of the 19 recommendations and the rest are in progress. Improvements include updating many policies and forms, and training staff on the new material. The Ministry is also continuing to review its education, marketing and outreach tools with a view to improving awareness about driving with high-risk medical conditions, and has improved its education and outreach efforts by operating Diabetes Education Programs in partnership with the Ministry of Health and Long-Term Care.

Several of the outstanding recommendations are addressed in *Bill 31, the Transportation Statute Law Amendment Act (Making Ontario's Roads Safer), 2015*, which received royal assent on June 2, 2015. This legislation allows for future regulations that will provide more clarity in the process for identifying potentially dangerous medical conditions, and for nurses and other qualified medical professionals to report drivers with conditions that may make it dangerous for them to drive. The Ombudsman will closely monitor the Ministry's progress in developing these regulations.

The Code – Ministry of Community Safety and Correctional Services



In June 2013, the Ombudsman released *The Code*, his report on how the Ministry of Community Safety and Correctional Services responds to allegations of excessive use of force against inmates by correctional staff.

The Ombudsman's investigation was launched after we flagged a disturbing trend, dating back to 2010, of hundreds of complaints about the use of force by correctional officers against inmates. It revealed that in many cases, the use of force on vulnerable inmates was excessive and often covered up to thwart investigation.

The Ombudsman found that an entrenched "code of silence" among some correctional staff was the root of the problem, hurting vulnerable inmates as well as staff who attempted to speak out about excessive force by colleagues. He made **45** recommendations to the Ministry to improve investigative procedures and staff training in correctional facilities. The Ministry agreed to act on all of the Ombudsman's recommendations, and reports to our Office on its progress every six months.

The Ministry has implemented **37** of the Ombudsman's recommendations in the past two years, and continues to work on the remainder, which include installing closed-circuit video in all facilities and universal use of hand-held video recording in potential use-of-force situations. Along with specifically identifying the "code of silence" as grounds for discipline and dismissal, the Ministry has revamped its policies and procedures for the reporting and investigation of use-of-force incidents, and clarified the circumstances in which correctional staff are authorized to use force against inmates.

As well, it has improved its recruitment process for correctional staff, including adding mandatory psychological assessments, and updated its training with material that provides clear instruction on ethical conduct and the use of force.

As noted in the **Operations** section of this report, the number of complaints to our Office about correctional staff using excessive force on inmates has increased – to **79** this past year, from 71 in 2013-2014.

In response to the Ombudsman's recommendations, the Ministry introduced a new policy relating to the investigation of incidents of use of force and the completion of documentation. Since then, we have received complaints about lengthy delays in this investigation process, with some cases taking as long as six months. Our Office is working with the relevant Assistant Deputy Minister to address this issue.

In the Line of Duty – Ontario Provincial Police and Ministry of Community Safety and Correctional Services

In October 2012, the Ombudsman released *In the Line of Duty*, his report on how the Ontario Provincial Police (OPP) and the Ministry of Community Safety and Correctional Services were dealing with operational stress injuries, including post-traumatic stress disorder (PTSD), affecting police officers. The investigation, sparked by a complaint from former OPP Detective-Inspector Bruce Kruger, revealed the lack of services, training and education for OPP members on the issue of operational stress injuries – in particular, the lack of a suicide awareness and prevention strategy to combat suicides within the OPP, which outnumbered deaths of officers in the line of duty between 1989 and 2012.

The Ombudsman has noted the OPP's enthusiasm and commitment in acting upon his **28** recommendations (another **six** recommendations were directed at the Ministry). In September 2014, he wrote to the Commissioner of the OPP to confirm that it no longer needed to provide our Office with formal updates every six months.

SORT has continued to obtain status updates from the OPP on an informal basis. In particular, we are following the OPP's progress on implementing a suicide prevention program, the expansion of psychological services for specialty units, and the hiring of a full-time OPP psychologist.

Among the notable steps taken by the OPP since the report's release:

- Creating seven permanent, full-time positions for leaders of Critical Incident Stress Response Teams, which provide peer support for OPP officers;
- Training external clinicians to become familiar with OPP culture;
- Informal lunch-and-learn sessions for officers on mental health awareness;
- A pilot workshop for OPP supervisors on how to recognize early signs of operational stress injury;
- Meeting with municipal and regional police services to exchange ideas on how to address operational stress injuries;
- Enhanced assistance services for retired members;
- Educating members as part of annual training on available support services, critical incident stress management, and building resiliency;
- Establishing the OPP Wellness Unit to provide peer-based support services, training and prevention programs;
- Implementing a mental health and resilience training program called "Road to Mental Readiness" for human resources staff, managers and employees, based on training developed and delivered by the Canadian Forces.

The Ministry also committed to developing a provincewide confidential survey to assess how many active and retired officers in other police services across the province have operational stress injuries. The survey for active officers has been completed; it received approximately 14,000 responses (a 42% response rate), and an analysis is underway. A survey of retired officers is ongoing.

The Ministry is also:

- Working with the Office of the Chief Coroner to identify officer and retired officer suicides;
- Creating a new "Resiliency and Wellness" instructor position at the Ontario Police College;
- Co-ordinating information sharing with police services across the province to address operational stress injuries and suicide prevention;
- Engaging in research to develop provincewide standards for police services and police services boards on operational stress injuries;
- Integrating "Road to Mental Readiness" training, including how to recognize signs of operational stress injury, into basic constable training at the Ontario Police College and into courses for those who deliver in-service training for existing officers.

> "I'm a former OPP who left after serving only 12 years... I have suffered with PTSD for many decades and didn't know it. I have lost a marriage, jobs, relationships, self-medicated, I also suffered from anxiety, anger, etc. I knew there was something wrong and couldn't understand why I was the way I was... I have been to a psychiatrist and put on medication and just today went to my first session with a PTSD counsellor. It's going to be a long road, but the burden I have been carrying has been lifted and I know there is light at the end of the tunnel. If Bruce Kruger had not contacted you and you had not taken action, I know I would not have had a chance to know what having peace in my life might feel like."
>
> – FORMER OPP OFFICER, *BE IN THE LINE OF DUTY*, FEBRUARY 2015

Non-emergency medical transportation services – Ministry of Transportation and Ministry of Health and Long-Term Care

In January 2011, the Ombudsman announced an investigation into whether the Ministries of Transportation and Health and Long-Term Care were taking appropriate steps to ensure the safety of the public who use non-emergency medical transportation services. The Ombudsman's investigation identified issues with poorly maintained vehicles, untrained staff, lack of appropriate equipment and infection control, and no mechanism for handling complaints from the public.

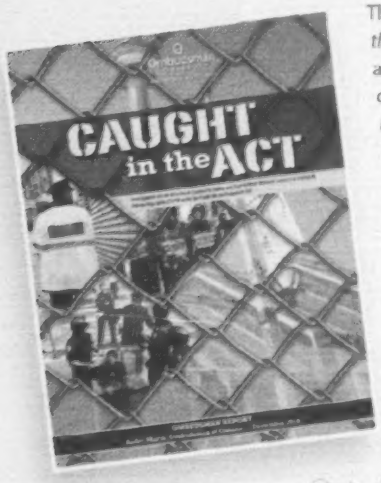
In May 2011, the Ombudsman shared his findings with both ministries. In response, then-Minister of Health and Long-Term Care Deb Matthews and then-Minister of Transportation Kathleen Wynne announced that legislation would be introduced to regulate non-emergency transportation services.

In December 2013, amendments were introduced to the *Highway Traffic Act* that would have allowed for some regulation of the industry, but the proposed legislation died on the order paper due to the June 2014 election. In September 2014, now-Premier Wynne identified "establishing a regulatory framework for non-medical transportation services" in her public "mandate letter" setting out priorities for the Minister of Transportation.

In April 2015, new amendments to the *Highway Traffic Act* were introduced (now as Bill 85). The proposed changes will bring much-needed regulation to non-emergency medical transportation – which both ministries now refer to as "stretcher transportation services." Under the new legislation, the Ministry of Transportation will be responsible for regulations ensuring that vehicles are fit for purpose and operators meet certain qualifications and standards. As well, the Ministry of Health and Long-Term Care is bringing in new guidelines for hospitals choosing and contracting non-emergency medical transportation service providers.

The Ombudsman will review the new regulations once they are drafted and will continue to monitor the progress of both ministries on meeting their commitments to better oversight of this industry.

Caught in the Act – Ministry of Community Safety and Correctional Services



The Ombudsman's December 2010 report, *Caught in the Act*, examined the Ministry of Community Safety and Correctional Services' role in the quiet promotion of a regulation under the World-War-II-era *Public Works Protection Act (PWPA)* to give police extraordinary powers during the G20 summit held in Toronto in June 2010.

The *PWPA*, first enacted in 1939, was essentially a "war measures" act, intended to protect critical infrastructure in the event of wartime invasion. The Ombudsman found it was wrongly used to allow Toronto Police, who were responsible for policing outside the temporary security fence erected around downtown, to detain some 1,500 people – mostly peaceful protesters and innocent bystanders.

> "Here in 2010 is the province of Ontario conferring wartime powers on police officers in peacetime. That is a decision that should not have been taken lightly or kept shrouded in secrecy, particularly not in the era of the Canadian Charter of Rights and Freedoms... By creating security zones to bar entry and by authorizing arrest, it imposed definite limits on freedom of expression."
>
> – OMBUDSMAN ANDRÉ MARIN, *CAUGHT IN THE ACT*, JUNE 2010

He recommended that the little-known *PWPA* be repealed to prevent future abuse of its outdated provisions, and that the Ministry ensure the public is informed about any future changes to police powers for special events.

The government and a task force it appointed, headed by Hon. Roy McMurtry, quickly agreed to these recommendations, but repealing and replacing the law took more than four years. Bills to replace the *PWPA* twice died on the order paper, due to elections in 2012 and 2014.

In December 2014, Bill 35 was passed and given royal assent, repealing the *Public Works Protection Act*. It also amended the *Police Services Act* to provide for security at court facilities, and enacted the *Security for Electricity Generating Facilities and Nuclear Facilities Act, 2014*, which governs security at electricity generating facilities and other critical infrastructure. The legislation was proclaimed in force on June 24, 2015, two days short of the five-year anniversary of the summit.

The courts continue to deal with class action and individual lawsuits against the province and police with regard to civil liberties violations during the G20. In March 2015, the Ontario Court of Appeal ruled that the rights of a would-be demonstrator were violated when a group of York Regional Police officers (part of the joint force policing the area), refused to allow him and his friends to continue downtown without being detained and searched.

In an encounter that was recorded on video and widely circulated on YouTube, the officers told the man:

> "This ain't Canada right now... There's no civil rights in this area ... You're in G20 land now."

Although the three-judge Court of Appeal panel noted that they were not ruling on the behaviour of police in general during the G20, they found the actions of these officers violated the man's constitutional right to freedom of expression. They also found the police actions "were not reasonably necessary and had little, if any, impact in reducing threats to public safety, imminent or otherwise."

> "[T]he police did not have the power to target apparent demonstrators and require that they submit to a search in order to continue down a public street... [They] violated [the demonstrator's] common law right to travel unimpeded on a public highway, and ... also violated his Charter right to freedom of expression."
>
> ▶ ONTARIO COURT OF APPEAL JUSTICE PAUL ROULEAU, *FIGUEIRAS VS. TORONTO (POLICE SERVICES BOARD)*, MARCH 30, 2015

Monitoring of long-term care homes – Ministry of Health and Long-Term Care

We have monitored developments in the Ministry of Health and Long-Term Care's program of inspecting long-term care homes since the Ombudsman launched an investigation in the summer of 2008. In December 2010, he issued an update on the case, noting that because of significant changes to legislation, the Ministry's program was a "work in progress." In lieu of a full report, the Ombudsman and SORT have kept a close eye on the Ministry's Compliance Branch and the implementation of its Long-Term Care Home Quality Inspection Program.

In the past year, we received **25** complaints about the Compliance Branch, including concerns about delayed inspections and the quality of inspections. We also received **84** complaints directly related to long-term care homes, which we had to turn away, as they remain outside of the Ombudsman's jurisdiction (more information about this is included in the **MUSH sector** section of this report).

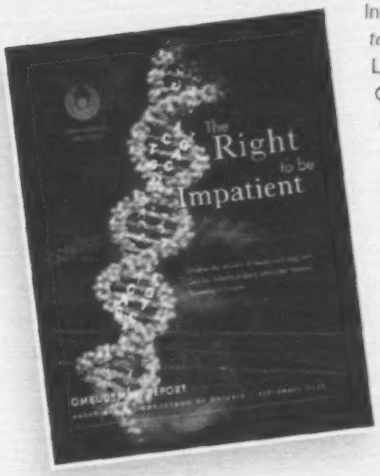
In early December 2014, concern was expressed in the Legislative Assembly that the government had failed to live up to its April 2014 promise to conduct a "resident quality inspection" (RQI) in every long-term care home by the end of that calendar year. The Ministry responded that all inspections were targeted for completion by mid-January 2015.

An RQI is a two-stage, comprehensive inspection that includes interviews with residents and observations about their care, as well as inspections with a focus on quality of care and quality of life indicators. Our inquiries determined that the Ministry had hired and trained 88 contract inspectors, and that as of January 30, 2015, it had completed RQIs for all 629 long-term care homes. Reports of these inspections were posted on its public website by the end of February 2015.

We also monitored the Ministry's progress in ensuring timely enforcement of its compliance orders and follow-up inspections, in the wake of concerns about delays. The Ministry said it has developed data reports to better track these orders and inspections.

In addition, our staff alerted the Ministry about several egregious complaints about long-term care residents being abused, neglected and left in unsanitary and unsafe conditions, and complaints to its "action line" going unheard. The Ministry responded with inspections and increased monitoring at some of the homes in question, and pledged to follow up with the residents' families; we will continue to monitor these cases.

The Right to be Impatient – Ministry of Health and Long-Term Care – Newborn screening



In September 2005, the Ombudsman published *The Right to be Impatient*, his report on the Ministry of Health and Long-Term Care's administration of newborn screening in Ontario. The primary goal of newborn screening is the early identification of affected infants in time to prevent serious health problems. The investigation revealed internal Ministry documents that estimated that as many as 50 children per year were dying or becoming severely disabled due to disorders which the program could easily have been expanded to detect, if not for what the Ombudsman described as "bureaucratic lethargy."

> "I urge the Ministry to heed the lessons learned from the sad history of newborn screening in Ontario... [A]s a result of inertia, inattention and abdication in the past, children have needlessly died and been rendered disabled. If this realization does not motivate this government to stay the course, nothing I recommend will ever do so."
>
> ▶ OMBUDSMAN ANDRÉ MARIN, *THE RIGHT TO BE IMPATIENT*, SEPTEMBER 2005

The government immediately acted to expand the number of genetic screening tests. Prior to the investigation, Ontario babies were tested for only two disorders. Today, Newborn Screening Ontario (NSO), based at the Children's Hospital of Eastern Ontario in Ottawa, co-ordinates screening across the province for 29 disorders. It has a mandate to ensure that testing is done in a timely fashion.

In April 2015, several media articles reported that delays in the process were potentially putting babies at risk. The *Toronto Star* reported that an estimated 15 of the 142,500 babies born each year screen positive for aggressive diseases that need to be detected in the first week of life for effective treatment. Factors reportedly contributing to the delays were NSO not operating on weekends, and hospitals and/or midwives not submitting newborn blood samples to NSO's lab immediately, but sending them in batches. The newspaper cited the case of one baby born over the October 2014 Thanksgiving weekend whose positive screen for one disease was not known for five days.

> "When babies' lives are at stake, hours, not just days, make a huge difference. Newborn screening needs to be designated an essential service so that no other family goes through what we had to."
>
> – MOTHER OF BABY WHOSE SCREENING SAMPLE WAS DELAYED, QUOTED IN *TORONTO STAR*, APRIL 13, 2015

Our Office made inquiries with the Ministry of Health and Long-Term Care and NSO to determine the steps being taken to address delays. NSO reported that it had established a data warehouse in summer 2014 and a reporting and audit tool in January 2015 to track blood sample transport time. We were told it has seen marked improvement since then, and it continues to analyze this data. It is also evaluating the feasibility of weekend operations and studying the logistics of a weekend courier service for hospitals and midwifery practices to send samples to NSO. We will continue to monitor the progress and result of NSO's evaluation to ensure the program is timely and effective.

Between a Rock and a Hard Place – Ministry of Children and Youth Services

In his first systemic investigation report, released in 2005 and entitled *Between a Rock and a Hard Place*, the Ombudsman revealed the disturbing problem of parents of children with severe special needs who were unable to obtain care for them unless they surrendered them to the custody of children's aid societies (CASs). The government immediately committed to ensuring that this would not happen again. However, cases persist where parents are told that the only way they can get residential care for their children is to give up custody, and Ombudsman staff work to resolve these whenever they arise.

We received **six** such complaints in 2014-2015 – an increase over the previous three years, although significantly less than the disturbing number (44) flagged by the Ombudsman in 2010-2011. Three of the cases involved CAS and Ministry officials from the Central region, and there was one each involving the Toronto, East and West regions.

Five of these cases involved boys aged 9-15 with severe special needs such as autism, fetal alcohol syndrome and violent behaviours; four needed to be placed in residential care, while one required significant support so he could remain at home with his mother. In these cases, the families were wrongly told – both by CAS workers and local service co-ordination agencies – that there was "no money" for treatment unless they placed the children in CAS care. Two of the families surrendered custody in desperation and needed our Office's help to have it restored.

The sixth case involved a girl who was abandoned by her family because they could not cope while waiting for an appropriate placement and treatment for her. She was identified as having several severe behavioural problems, manifesting in sexually assaultive behaviour, homicidal intentions and suicidal thoughts. In this case, it was the CAS that flagged the family's situation to the Ministry, noting that they had given up custody "because the mental health/community system was unable to respond and provide the specialized and intensive services for her."

Ombudsman staff worked with senior Ministry officials, who directed the relevant local service co-ordination agencies in the five boys' cases to apply for complex special needs funding. The urgent funding requests were approved. In the girl's case, the Ministry took steps to ensure she received the necessary placement and supports. In all of the cases, the children received access to the treatment they needed.

> "[*Between a Rock and a Hard Place*] was a powerful and objective report of a systemic challenge parents and children face in accessing care and services... I am pleased the issue continues to be followed, as does lack of services for the adult population with special needs. Thank you for your continued diligence in investigating this unconscionable issue."
>
> – ANNE LARCADE, VIA FACEBOOK, APRIL 2015

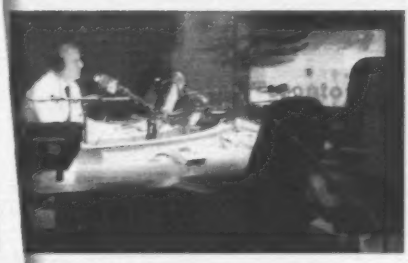
Communications and Outreach

Ever since the first ombudsman was created in Sweden more than 200 years ago (the word "ombudsman" is Swedish for "people's representative"), communication with the public has been integral to the role. Our Office makes use of all available means of communication, from traditional in-person events and print publications to digital and social media, to engage and inform Ontarians in the most effective way possible. Over the past 10 years, the Ombudsman has kept pace with technology, incorporating web and social media tools in investigations as well as communications.

Traditional media

In 2014-2015, there were **1,163** news articles published about the Ombudsman's Office, primarily in daily newspapers across Ontario and the rest of Canada. The estimated advertising value of these articles was **$2.2 million**, reaching an aggregate audience of **54.2 million** people, according to calculations by Infomart, based on newspaper advertising rates, circulation and page display. There were also **607** news items about the Ombudsman and our Office's work broadcast on radio and television in Ontario and across Canada in 2014-2015. Cumulatively, from April 1, 2005 to March 31, 2015, media coverage of the Office reached an aggregate audience of 766 million, with an estimated value of $25 million.

TORONTO SUN
BACK TO WORK?
MORE CHARGES FOR HOCKEY PREDATOR
HYDRO NONE
Page 4
After more than 10,000 complaints, ombudsman Andre Marin concludes what we all knew – Hydro One is a complete 'mess'



Social media

The Ombudsman's **Twitter** account (**@Ont_Ombudsman**), launched in 2009, reached more than **30,353** followers as of March 31, 2015, a 52% increase over the previous year. In April 2015, we launched a designated French account (**@Ont_OmbudsmanFR**), to reach a broader audience in both official languages and quickly garnered hundreds of followers. Ombudsman André Marin tweets personally on both accounts; tweets by Communications staff are marked as "COMMS." We use Twitter to share information about our Office, our work, and news of interest in the oversight field (for example, #Bill8 and the expansion of our jurisdiction). Events such as press conferences and speeches are also live-tweeted with the hashtags #OOLive and #OOendirect.

Our Office's following on **Facebook** grew to **3,835** likes in 2014-2015, marking a 32% increase over last year. Views of our YouTube videos (primarily press conferences and speeches) increased 45%, to **37,889**. The most popular YouTube video was about the 2013-2014 Annual Report, which garnered 1,855 views after it was shared by several news media in June 2014.

> "The feed of @Ont_Ombudsman is informative, witty and insightful... He's civilized and open."
>
> ▶ @DylanDwyer

> "Andre Marin @Ont_Ombudsman on Global News right now. I like his outreach techniques."
>
> ▶ @55ENG

> "@Ont_Ombudsman Appreciate the amount of info available on the website, YouTube, Twitter and reports. Ont Gov should take note #transparency."
>
> ▶ @Bobm87

> "Following @Ont_Ombudsman is a must. Insightful, informative, provocative and frequently hilarious. #moreplease"
>
> ▶ @TishS55Tosh

Website

The Ombudsman's website, **ombudsman.on.ca**, is a one-stop resource for anyone who wishes to file a complaint, access the Ombudsman's reports and videos, read news and information about our Office, or find us on social media. According to Google Analytics, the site had **119,451** visitors this past year, a slight (5%) decrease from the previous year's record high. There were **174,262** total visits and **615,710** pageviews, and visitors came to the site from **179** countries.

For users of mobile devices, we also have a mobile-optimized version of our site, which attracted 17% more visitors in 2014-2015 (**38,522** unique mobile visitors). There were **52,005** total visits and **122,556** pageviews.

Awards

For the second year in a row, Ombudsman André Marin was named one of the country's top lawyers as part of *Canadian Lawyer* magazine's "Top 25 Most Influential Lawyers" list. Voters for the August 2014 article praised Mr. Marin as a "highly reputable and responsive" official who "listens to the people" and takes action against "unfair policies" by Ontario government agencies. The magazine noted that his "determination" to shine a light on government "led Ontario to table legislation expanding the ombudsman's powers of oversight to municipalities, universities, and school boards."

Mr. Marin was also named one of *Ottawa Life* magazine's "Top 25 People in the Capital." Dubbing him the "Defender of Public Complaints," the magazine pointed out that most of the Ombudsman's recommendations had been accepted by government, adding: "With over 20,000 complaints coming into his office every year, Marin clearly also has the trust of Ontario people. He continues to successfully delve into issues affecting thousands of Ontarians."

Outreach

The Ombudsman and senior staff were invited to speak to a wide variety of events and groups in 2014-2015, many focusing on the impending changes being ushered in with Bill 8. We continue to reach out to organizations in the "MUS" sector (municipalities, universities and school boards) that our Office will soon oversee.

For example, the Ombudsman and our Senior Counsel discussed municipal oversight at several conferences organized by municipal stakeholders, including the Association of Municipal Managers, Clerks and Treasurers of Ontario. The Ombudsman also spoke about school board oversight to the Ontario Catholic School Trustees' Association and the College of Teachers. As well, he and senior staff spoke to several university student groups and the Council of Ontario Universities about how we will handle complaints about universities.

November 3, 2014: Ombudsman André Marin is the invited speaker at a public town hall meeting in Yellowknife, NWT on the merits of establishing a territorial ombudsman.

Among many other speaking engagements, the Ombudsman was invited in November 2014 to address a public town hall meeting in Yellowknife on the importance of ombudsman oversight, as part of efforts to establish an ombudsman for Northwest Territories (the territorial government opted to put off discussion of the idea until after the next election). As well, the Ombudsman was invited to speak about our Office's role in public sector law and police oversight, including to the Canadian Bar Association, the Ontario Association of Police Services Boards, the U.S.-based National Association for Civilian Oversight of Law Enforcement, and the County of Carleton Law Association's civil litigators' conference.

Ombudsman staff participated in several community events to share information about our Office, including the Scarborough-Agincourt Health and Government Services Information Fair, the Etobicoke Government and Community Services Fair, and the Osgoode Hall Public Interest Day. Outside of work hours, the Ombudsman and our various teams joined in several charity events, including the Canadian Breast Cancer Foundation's Run For the Cure, Movember to raise awareness of prostate cancer, and the ALS Association's 2014 Ice Bucket Challenge (all pictured above).

Training and consultation

The Ombudsman's training course, "**Sharpening Your Teeth: Advanced Investigative Training for Administrative Watchdogs**" (or SYT for short), has been delivered each year in Toronto and elsewhere upon request since 2007, always on a complete cost-recovery basis. Hundreds of ombudsmen and staff from watchdog agencies across Ontario, Canada and around the world have participated in this course, learning from our Office's experience and expertise in conducting systemic investigations.

In 2014-2015, the Ombudsman and senior staff delivered customized versions of SYT at the International Law Enforcement Auditors Association in Texas and the Office of the Financial Services Ombudsman in Trinidad and Tobago.

Our annual Toronto SYT training conference was held in January 2015, and welcomed, among others, representatives from the Office of the Ombudsman of Nova Scotia and New York City's Department of Investigations, as well from the offices of Ontario's Civilian Police Commission, Financial Services Commission, Integrity Commissioner and Official Languages Commissioner. Ontario's Public Guardian and Trustee and Toronto's Commissioner of Housing Equity attended, along with several other high-ranking public servants.

Comments from SYT 2015 participants:

"All of the content was useful. A lot of light was shed into the functions of the Office of the Ombudsman, how it is structured and how it ultimately decides to embark on a systemic investigation."

▶ SPECIAL INVESTIGATOR, NEW YORK CITY DEPARTMENT OF INVESTIGATIONS

"I find the content quite useful. It is relevant to my work. I plan to integrate my learning into my work. Also looking forward to sharing strategies with my staff."

▶ PROGRAM SUPPORT MANAGER, CITY OF TORONTO

"I liked the practical and logical progression of the materials and topics."

▶ COMMISSIONER OF HOUSING EQUITY, CITY OF TORONTO

"Very helpful. Reaffirmed investigation practices. Very practical tools for preparing for an investigation."

▶ HUMAN RIGHTS AND DIVERSITY SPECIALIST, HAMILTON HEALTH SCIENCES

Our Office also frequently receives requests to meet with delegations from oversight bodies in other jurisdictions. As noted in last year's Annual Report, the Ombudsman hosted the annual meeting of his counterparts in the Canadian Council of Parliamentary Ombudsman in Toronto in May 2014, to discuss best practices, mandate changes and engaging the public. Among the international delegations to visit our Office in 2014-2015 were the Banking Ombudsman of New Zealand, senior staff from the office of the Ivory Coast Ombudsman and the Public Service Commission of South Africa, and groups from Guangdong Province and the Beijing Municipal Commission for Discipline Inspection in China.

As well, senior Ombudsman staff consulted with and gave presentations about how we work to representatives of Ontario ministries, agencies and interest groups, including the Death Investigation Oversight Council, Home Child Care Association of Ontario, Adult Protective Service Association of Ontario, and Office of the Public Guardian and Trustee.

Ombudsman
ONTARIO

CASE SUMMARIES

MINISTRY OF THE ATTORNEY GENERAL

Criminal Injuries Compensation Board

Pearly rights

A woman whose teeth had been damaged as a result of physical abuse by her partner years earlier contacted the Ombudsman for help in obtaining funds to have them fixed. In 2009, she had been awarded $20,000 in compensation for pain and suffering by the Criminal Injuries Compensation Board, which helps ease the financial burden of victims of violent crime. At that time, the board told her it would consider providing additional compensation for future dental expenses, but when she applied, she was told it would only pay for dentures, not the other dental work she needed, including tooth extraction in order to fit the dentures, which would cost more than $5,000.

Ombudsman staff reviewed the board's original decision, which found the woman's broken, decayed teeth were related to domestic abuse – a conclusion supported by medical and police records. However, the board member who heard her subsequent application for funds to cover dental work said there was no medical evidence to support her claim.

Given the two contradicting decisions, our Office urged the board to reconsider, and within two days, it awarded her additional funds for her dental work and dentures.

MINISTRY OF CHILDREN AND YOUTH SERVICES

Handling with care

The aunt and uncle of a 16-year-old boy with Down Syndrome needed help finding the boy a place to live after his mother died of cancer. They were concerned that they would not be able to care for him because they lived 270 kilometres away, both worked odd hours, and, due to their age, wouldn't be able to look after him on a long-term basis.

The nephew was receiving help from a Ministry-funded service provider in his community, but the agency said there was nothing it could do to help find somewhere for the boy to live. It suggested they contact the relevant children's aid society.

Ombudsman staff contacted officials at the Ministry of Children and Youth Services, who were able to find the boy a family home provider in the couple's community, as well as assign him a case manager and other local resources. The aunt and uncle were able to continue having a relationship with their nephew and were extremely pleased with his placement. The Ministry also said it would follow up with the local service provider, letting it know that its suggestion to contact the children's aid society was wrong (as there were no protection concerns), and that it should co-ordinate with similar services in other regions to find the best possible solution for clients.

CASE SUMMARIES

Bullied and baffled

A mother contacted us in frustration because she couldn't get help for her nine-year-old daughter, who had been severely bullied and injured at school, and was expressing thoughts of self-harm.

The woman tried multiple times to take her daughter to a hospital, which kept referring her to a local community service agency. The agency told her the case wasn't urgent and put her daughter on a waiting list for counselling. Workers at the agency said they were understaffed and overwhelmed with referrals. Meanwhile, the daughter had to be schooled at home for a year.

Ombudsman staff raised the case with the program supervisor at the Ministry of Children and Youth Services, who immediately contacted the local service agency. The girl was provided urgent therapy and referred to a day treatment program for respite services. The hospital also apologized to the family. The mother told our Office she was baffled as to why no one could help her previously, and thanked the Ombudsman for getting things moving.

MINISTRY OF COMMUNITY AND SOCIAL SERVICES

Ontario Disability Support Program (ODSP)

Going the distance

The owner of a home for adults with mental health issues contacted the Ombudsman, frustrated that he couldn't get ODSP or Developmental Services Ontario (DSO) to provide funding to take one of his residents to her cancer treatments. The resident wasn't capable of travelling to the treatments by herself, and it meant the owner had to pay staff to cover for him at the home while he drove her to and from medical appointments.

Our Office brought this issue to the attention of staff at the ODSP, DSO and a community outreach agency, and facilitated communication between these agencies and the owner of the home. The local agency agreed to have a worker take the resident to her cancer treatments, and DSO put her on waiting lists for additional funding.

Past the due date

The mother of a young man with significant mental health problems came to the Ombudsman because her son, who was receiving ODSP benefits, had been threatened with eviction from his group home because his rent had not been paid via ODSP. The mother had scraped together two months' rent for him but could not afford to pay for a third month.

Ombudsman staff brought the case to an ODSP manager, who discovered the man's case worker had gone on maternity leave and no replacement case worker had been provided. This lapse meant the ODSP's files weren't up to date. It was not aware the man had moved recently, and had been sending his rent to his previous landlord. The manager immediately assigned another case worker and the man's former landlord reimbursed the ODSP for three months' rent it had paid on his behalf.

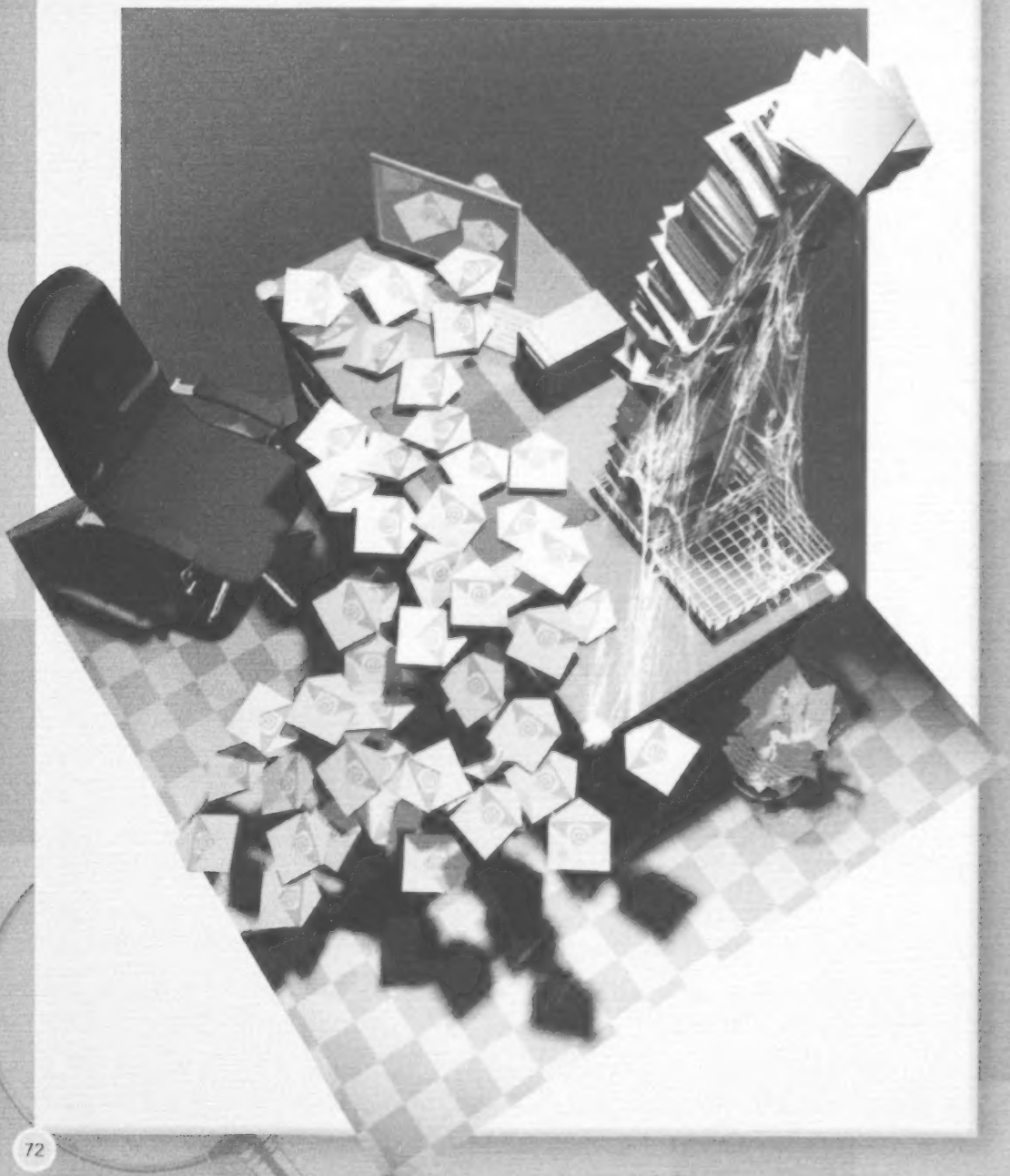
The mother was reimbursed for what she had paid.

CASE SUMMARIES

Labour pain

A woman came to us after she could not reach her ODSP case worker for two months. The woman was receiving Employment Insurance benefits of $295 per week, which were deducted from her monthly ODSP cheque of $1,842, but they had ended two months earlier. Despite this, the ODSP continued to take deductions from her cheque.

An Ombudsman staff member contacted an ODSP manager, who determined that the woman's worker had gone on maternity leave and no one had taken responsibility for her files. As a result, the ODSP reimbursed the woman $1,800 for the erroneous deductions.



CASE SUMMARIES

Family Responsibility Office (FRO)

Wrong, wrong, wrong

A woman complained to the Ombudsman in May 2013 that her ex-husband owed $46,000 in spousal support and the FRO was not enforcing a court order that he pay it.

According to the FRO, since the man had filed for bankruptcy in 2011, it couldn't take action against him for any of the support owing since that time. In fact, unpaid support from the year prior to the bankruptcy was off limits, but any support accrued since then was not. In November 2013, the FRO filed a claim on her behalf with her ex-husband's bankruptcy trustee.

However, the woman contacted us again in 2014 because the FRO's claim contained the wrong information about the amounts owing, and it still wasn't taking any enforcement action against her ex-spouse, who had not paid any of the arrears or the full monthly support amount she was owed.

Ombudsman staff spoke with the FRO and the Office of the Superintendent of Bankruptcy, confirming that the FRO had submitted incorrect information and failed to follow its own policies when filling out the forms. FRO staff resubmitted the claim with the correct information and began enforcement action. As a result, the ex-husband started paying the court-ordered monthly support and some of the unpaid support arrears. The FRO also wrote to the woman and acknowledged its enforcement delays and errors.

Settling an account

A man contacted our Office because he suspected the Family Responsibility Office had miscalculated the amount he owed for child and spousal support by almost $3,800. He had written the FRO three times in the past 18 months, but it did not acknowledge his letters or adjust his account.

After we looked into it, FRO staff confirmed their error. They adjusted the arrears and credited the man's account $3,774.59. The man was very grateful and thanked the Ombudsman for helping resolve an issue he had been trying to address for years.

CASE SUMMARIES

Way out west

A single mother complained to the Ombudsman that she hadn't received child support payments in six months, despite her daughter, a post-secondary student, still living at home. The father lived in B.C., and as long as the daughter attended school and lived with her mother, he was required to pay monthly support payments. The case was registered with the FRO's Interjurisdictional Support Orders unit (ISO).

Ombudsman staff reviewed the case with a manager at the ISO and discovered the B.C. Family Maintenance Enforcement Program had sent two letters to the FRO to be forwarded to the mother, asking her to confirm her daughter's attendance at a post-secondary institution. The FRO had no record of the first letter and delayed forwarding the second letter for almost four months. As a result, the B.C. program closed its file, retroactive to the daughter's last birthday.

When the mother sent proof of her daughter's enrollment, the B.C. organization reopened the file. However, its policy was not to enforce child support accrued during the nine months the file was closed (about $1,800). The FRO wasn't able to get the B.C. program to make an exception to its policy, but determined that it could collect the outstanding amount once the B.C. program closed its file.

Ombudsman staff pointed out to the FRO that the woman shouldn't have to bear the burden of its delays. It agreed to reimburse the mother immediately for the nine months of support.

The FRO also implemented changes in its ISO unit to prevent future delays, including designating a point person to receive all child status letters from other jurisdictions.

CASE SUMMARIES

Developmental Services Ontario (DSO)

A sign of relief

A mother was concerned about the lack of support and funding for her 19-year-old son, who has autism and aggressive behavioural issues. He had recently been taken to hospital by police after an incident when he became agitated and violent. The family had short-term support workers funded by the Ministry of Community and Social Services through a staffing agency, but the workers were unreliable, causing additional stress for the son. As the sole caregiver, the mother worried she wouldn't be able to keep herself and her son safe in her home.

Ombudsman staff made inquiries with DSO, two local service agencies and the Ministry, and discovered that the agencies had never told DSO about the family's recent difficulties. DSO officials met with the woman and her son immediately, resulting in a reassessment of his needs and a significant increase in the family's priority rating for extra supports. Staff at the local agency also agreed to review procedures to improve communication with their provincial counterparts.

The family was allocated $16,000 in annual funding through the Passport program, which provides funding for services and supports for adults with developmental disabilities. The mother told our Office she hoped to use the funding to find a day program for her son.

Crisis of care

The family of a 69-year-old woman with developmental disabilities contacted the Ombudsman because they could no longer care for her. She was in hospital after she was assaulted at her day program, but would have nowhere to live after she was discharged.

Ombudsman staff followed up with DSO and the Ministry of Community and Social Services, and a crisis worker was assigned for the woman. She was provided with emergency funding for support workers for the rest of her hospital stay, and given a temporary placement at a respite home.

The local Community Care Access Centre was also made aware of the situation, found a placement for the woman at a long-term care home, and put her on a waiting list for a residential care facility. She was able to continue her day program and received $11,000 per year in additional support through the Passport program.

CASE SUMMARIES

MINISTRY OF COMMUNITY SAFETY AND CORRECTIONAL SERVICES

No time to lose

An inmate was told after a colonoscopy that he likely had bowel cancer and would need surgery immediately – within a week. However, the jail's doctor told him the facility had no paperwork from the specialist, and it would be up to four weeks before he could even get an appointment for surgery. This was after the man's colonoscopy had already been delayed by a month because jail staff hadn't properly prepared him for the procedure when it was first booked.

When Ombudsman staff contacted the facility, they confirmed the man's colonoscopy had been delayed because of staff errors. The manager booked a follow-up specialist appointment, at which his cancer diagnosis was confirmed and surgery was scheduled as quickly as possible.

After the surgery, the inmate told us the surgeon reported he "got all the cancer." He thanked Ombudsman staff for helping him during a period of extreme anxiety. He finished serving his sentence a few months later and returned, cancer-free, to his wife and children.

Excruciating wait

An inmate had been waiting for months to have a wisdom tooth extracted and was in severe pain, to the point where he had fainted and had to be sent to hospital.

Ombudsman staff contacted the facility, but were unable to resolve the issue until it was escalated to a senior manager at the Ministry. The inmate had been complaining of pain for six months. The dentist had completed the necessary paperwork four months earlier, but staff failed to follow up with the proper approvals for surgical consultation. The inmate also hadn't been properly assessed for pain management, and was not getting painkillers, despite fainting from the pain.

After our Office intervened, the surgery was scheduled and the inmate was immediately provided with antibiotics, painkillers, and a soft diet. His tooth was successfully extracted within a few weeks.

Office of the Chief Coroner

Insuring a house is in order

Three months after his partner died, a widower contacted us because he had not received the coroner's report, despite writing the local coroner's office twice. His partner had died of what appeared to be a drug overdose and he needed the coroner's report to obtain life insurance payments. In the meantime, he was experiencing extreme financial difficulties.

An Ombudsman investigator contacted the Chief Coroner and discovered that the investigating coroner was waiting for a pathologist's report before he could sign off on the investigation. The regional supervising coroner helped clarify the situation with the insurance company, and the matter was resolved without the coroner's final investigation report.

The man thanked Ombudsman staff, saying, "you probably helped me save my house."

CASE SUMMARIES

MINISTRY OF ENERGY

Hydro One

Electrifying error

A woman was frustrated and confused by a dramatic increase in her electricity bills after her meter was changed in August 2013 – from $244 that July, to $403 in August, and up to $1,700 in January 2014. She said Hydro One was unable to provide her with an explanation for the increases, other than to tell her to get her wiring checked.

When Ombudsman staff asked Hydro One staff to review the woman's file, they discovered an error on her account that effectively resulted in her being charged twice for the electricity she used. Hydro One corrected the error and gave her a credit for **$2,613.77** for the overbilled amount, as well as a 12-month service credit of **$288.84** to compensate for the poor experience.

The woman was very appreciative, and commented: "It was right there in front of everyone's eyes to see but no one [at Hydro One] took the time to investigate."

Hydro Shock. Illustration from Annual Report 2010-2011

CASE SUMMARIES

Overbill overkill

A farmer was concerned about the high electricity bills he received for the first six months of 2014, even though his corn dryer – the machine on his farm using the highest amount of electricity – wasn't in use. His bills were close to $9,000, including $843 in delivery charges on $112 worth of electricity. When he called Hydro One, he was offered a payment installment plan and was told that due to his previous high usage, he had to pay for a higher amount of hydro to be available on demand.

Ombudsman staff requested a review of the man's bills and discovered that although his 2012 usage justified the higher-demand rates, his 2013 usage was actually much lower, and the charge was no longer applicable. He had been overbilled close to $6,000 in 2013. He was provided with the correct bills, as well as a service charge credit of $280.

MINISTRY OF HEALTH AND LONG-TERM CARE

Good medicine

A woman who was experiencing a third occurrence of HER2-positive breast cancer was denied funding by the Ministry for the chemotherapy drug Kadcyla, although it was prescribed by her oncologist. The Ministry would fund the drug for women experiencing a second occurrence of the disease, but not a third – despite scientific evidence that women with third and even fourth occurrences did benefit from the drug. The drug cost $4,600 every three weeks.

Ombudsman staff arranged for the woman's oncologist to write to the Executive Officer of the Ontario Public Drug Programs, as well as meet with officials to discuss the Ministry's funding criteria for the drug. After the meeting, the Ministry agreed to temporarily revise its funding criteria between October 2014 and October 2017 to include funding for some women experiencing third or fourth occurrences.

The oncologist estimated that approximately 100 women in Ontario will benefit from the temporary revision to the criteria in the next three years.

CASE SUMMARIES

New drug, new hope

After a woman was denied funding for a drug to treat neuropathic pain, her husband came to the Ombudsman for help. The woman has a rare neurological disease and her condition, which is considered palliative, means she has considerable muscle and nerve pain. One of the drugs that helped her pain, Sativex, was only approved for patients with multiple sclerosis, or palliative cancer patients with refractory pain.

When Ombudsman staff asked the Ministry's Exceptional Access Program to review the case, officials suggested the woman try a different drug, covered under the Ontario Drug Benefit Program. The drug helped control her pain, but she experienced severe side effects, including hallucinations, pounding in her chest, drowsiness, dizziness, anxiety and insomnia.

The Ministry ultimately agreed to consider her case and approved Sativex funding for six months, after which she will be reassessed to confirm if the drug has been effective. The family advised us the drug has eliminated the woman's pain, with minimal side effects.

Failure to communicate

After the removal of a benign brain tumour, a woman in her 20s suffered a stroke that left her unsteady on her feet, needing assistance to use the bathroom, and with speech difficulties. She had to be hospitalized several times and was placed in the complex care unit of a local hospital for four months.

The woman's mother turned to the Ombudsman for help in finding a residential placement for her. The hospital was pressuring the mother to care for her at home, but the local Community Care Access Centre could only provide a support worker for 16 hours per week, which would leave her alone during the day while her mother was at work. The CCAC and hospital wanted to move the daughter to a long-term care home, since there was no facility in the community for a person with such a brain injury, but she refused.

Ombudsman staff discovered communication problems between the service providers involved in the case. Some were not familiar with how the Ministry assists with funding for transitional housing for people with acquired brain injuries.

After our review, the daughter was placed in housing for women with similar injuries, which offered access to programs for physical and speech rehabilitation, within an hour of her mother's home. The CEO of the Local Health Integration Network also agreed to improve communication between local providers and services in the community and surrounding regions.

CASE SUMMARIES

Rehab reset

A mother complained to the Ombudsman after she was forced to pay $7,000 for a spot for her adult daughter in a residential treatment program for women with substance abuse issues. The daughter was just two days into the five-week program when a spot became available that was publicly funded through the Local Health Integration Network (LHIN). However, she wasn't permitted to take this spot, even though it remained empty. The woman felt the program shouldn't receive funds for an empty spot and that her $7,000 should be refunded.

The LHIN reviewed the woman's concerns at our Office's request, and arranged for the treatment program to reimburse the money for the full cost of the daughter's placement. It also acknowledged problems with the program's admissions process. The method of pre-screening applicants was inadequate, and one-third of patients dropped out of the program before completing it, leaving the LHIN paying the service provider for empty spots.

After our intervention, the LHIN committed to have the residential program redesign its admissions policy to ensure those enrolled are prepared to participate in a treatment program, including enlisting the help of a clinical psychologist as part of the screening process. The LHIN also committed to reviewing its other funded residential services to ensure they had appropriate admission policies and fewer empty beds.

Burden of proof

A woman turned to the Ombudsman for help when she had trouble renewing her Ontario Health Insurance Plan coverage. She had been living with friends and was struggling to provide proof that she was an Ontario resident so she could renew her OHIP card before it expired on September 30. She tried to renew it at a ServiceOntario office in late August with online bank statements, but these were rejected as proof of residence, since they hadn't been mailed to her.

The woman continued to gather additional information to establish her address, including documents from the Canada Revenue Agency, but before she could provide them, she received notice that her OHIP coverage had been cancelled because she didn't provide enough proof during her August visit.

Ombudsman staff contacted the Ministry of Health and Long-Term Care, which confirmed that ServiceOntario shouldn't have cancelled her health insurance prior to the expiry date and without allowing her to provide additional information. Ministry staff got in touch with the woman and were able to use the documents she had gathered to confirm her residency. Her health insurance was retroactively reinstated and the woman told Ombudsman staff: "You made my day."

CASE SUMMARIES

Lost in the mail

A 62-year-old woman with Crohn's disease required infusions every eight weeks at a cost of $4,542.76 per treatment. The woman's private insurance covered 80% of the costs, while the Trillium Drug Program reimbursed her for the remainder, but she was reaching the lifetime maximum for her private insurance coverage and it was about to end.

The woman contacted the Trillium Drug Program to make sure it had the information it needed to cover the full cost of her infusions in future. A Trillium agent asked the woman to provide a letter from the private insurer confirming the coverage was ending. The woman submitted the letter, then contacted Trillium again to confirm her account had been adjusted. A different agent told the woman she would need to submit a second letter confirming the date the private coverage would end. The woman did so, but was contacted by yet another Trillium staff member who asked her for a third letter confirming her benefits would not be reinstated in the future. She asked to speak to a supervisor, but didn't receive a return call.

After dealing with the issue for more than a month, the woman contacted the Ombudsman, frustrated and concerned that due to Trillium's convoluted system, her Trillium account wouldn't be adjusted to cover the costs of her next treatment, which was only three weeks away.

Ombudsman staff escalated the woman's concerns to senior Trillium staff at the Ministry of Health and Long-Term Care, who acknowledged the woman had received poor customer service and had been asked for unnecessary information. Trillium provides information to its call centre employees about what is required from a private insurer upon the termination of private coverage, but to prevent this situation in the future, the Ministry agreed that Trillium staff would be required to contact clients in writing to confirm what's needed if the initial information the client provides isn't adequate. The Ministry also agreed to update its website with more information about private insurance matters.

The Ministry expedited the review of the woman's application, and within three days of her call to the Ombudsman, her application was approved and her coverage was updated.

MINISTRY OF TRAINING, COLLEGES AND UNIVERSITIES

Tuition restitution

A student from outside of Canada, who was married to a Canadian citizen, chose to enter the country on an international student visa because it would be processed faster than her spousal visa. She enrolled at a college of applied arts and technology in fall 2013, and was enrolled during the fall and winter 2013 and winter 2014 terms. For each term, she was charged tuition based on international student rates, which were much higher than domestic student fees – about $7,000 per term. She didn't realize that dependents of Canadian citizens, including spouses, are eligible to pay domestic fees.

Ombudsman staff asked that the college's financial services department review the file. The college explained that the woman hadn't declared she was married to a Canadian when she enrolled. Recognizing this, the college adjusted her fees to match domestic fees, and refunded her $11,151.60.

CASE SUMMARIES

MINISTRY OF TRANSPORTATION

Your call is important

A 65-year-old man had his driver's licence suspended in May 2014 after hospital staff reported to the Ministry of Transportation that he had suffered a fall that knocked him unconscious. After this incident, the man provided the Ministry with letters from three different doctors confirming he was in good health, but two months later, his licence was still suspended, even though the Ministry was required to review the file within 30 business days. Every time he tried to call the Ministry, he was faced with an automated telephone system, which told him that his medical reports had been received and would be reviewed in the requisite 30 days, after which it would take six months to reinstate his licence.

The man contacted our Office because he was frustrated with not being able to speak to a real person and determine the status of his licence. During the suspension, it was taking him more than two hours and five buses to get to work every morning. After Ombudsman staff made inquiries with the Ministry, it reviewed the man's file – and less than a week later, his licence was reinstated.

Telephone Treadmill: Illustration from Annual Report 2012-2013.

CASE SUMMARIES

Return to sender, address unknown

A man contacted our Office in frustration when the Ministry repeatedly sent mail to his address for a former tenant. He had returned the envelopes several times with a note stating "this person does not reside at this address," but the Ministry mail did not stop.

When he contacted the Ministry to ask it to update its records, he was told that it could not change the information in its database unless contacted by the driver directly, not a third party. The Ministry also told him it requires notification from drivers and vehicle owners within six days of an address change.

Ombudsman staff asked the Ministry to review the issue. It responded that it doesn't have the resources or authority to trace and locate drivers, but that it would review the legislation and consider what could be done about similar cases.

Misplaced identity

A new driver complained to our Office after waiting six months for his permanent driver's licence. He had passed the written test and turned over his Ontario-issued government photo ID to ServiceOntario, expecting a replacement card in the mail, but he never received it.

When his mother followed up with ServiceOntario four months after his test, she was told the card had been mailed two months earlier. The man was concerned because he didn't have a photo ID to use, and his temporary driver's permit had expired, costing him $25 to renew.

Ombudsman staff contacted the Ministry of Transportation's Special Enquiry Unit and determined that due to an error, the young man's original photo card had never been cancelled, and it was holding up the computer system from issuing his permanent licence.

The Ministry immediately cancelled the photo card, couriered his permanent driver's licence to him, and reimbursed the $25 fee he'd paid to replace the temporary licence.

A matter of time

After signing up for "Back on Track," a remedial program for people convicted of impaired driving, a man phoned the program to book a one-hour assessment interview. He was given the choice of several time slots. He arrived at 3:30 on the appointed day, believing he was half an hour early for the 4 p.m. slot. Instead, he was told the interview had actually been booked for 3 p.m. – and because he was late, he would have to re-register for the program and pay the entire $578 enrollment fee again.

The man complained to the Ombudsman that this was unfair, because he believed he had been on time and that program staff had written down the wrong time when the appointment was booked. Further, he argued that if it was his error, it didn't make sense for him to pay almost $600 for being half an hour late – the penalty should have been a small late fee instead.

After many discussions with Ministry staff, the Ministry agreed that the program's response wasn't fair. They reimbursed the man's fee and made improvements to the appointment confirmation process. The program will now ensure the client repeats the date and time of the appointment, and send out written or electronic confirmations of appointment times when possible.

Your Feedback

"I applaud your vigilance, and that of your capable staff, in ensuring that Ontario government services meet the needs and expectations of the people of our province."

Letter from Premier Kathleen Wynne, April 15, 2014

"There are many people in power doing the right thing to help out others in the community, which makes things every day a little better. I want to thank you and others for the help, guidance, caring, etc. It really means a lot."

Complainant

"We commend the Ombudsman's office for creating the report *Careless About Child Care* and making 113 recommendations to improve child care in Ontario.... We thank you for such a comprehensive report and bringing this issue to the public."

Sheri Roberts, Chair, Home Child Care Provincial Council, October 2014

"Your annual reports underline the clear need for ongoing and independent oversight of provincial corrections, and we laud your organization's profiling of these important issues... We commend your Office's coverage of the complaints that come from correctional institutions, and encourage ongoing focus on the conditions and challenges endemic to our provincial correctional system."

Letter from John Howard Society of Ontario, May 2014

"Everything has really been settled to my satisfaction. Thanks a million for your help, I'm sure I would have gone on forever by myself. My compliments to you and thank God for the Ontario Ombudsman."

Complainant

"[The Ombudsman's] office was a great help in our fight with WSIB."

Complainant

"I would like to thank the Ombudsman once again for this great help extended to me, without which I would not have got the answers I was looking for. Thank you for helping families."

Complainant

Your Feedback

"How you did the work – with respect and kindness – has been so meaningful to us in the midst of something really terrible. We are always grateful for the support from Mr. Marin, from the whole team at the Office of the Ombudsman, and the very personal attention that you gave us."

Complainant

"You have been a great example for ombudsmen who may be reluctant to see the value in being tough, insistent, and proactive when necessary."

Letter from Irene Oh, Australian Red Cross, August 2014

"Thanks again for all your hard work, humour, blunt honesty and crap you take, to give the taxpayers and residents hope."

Complainant

"On behalf of our family and many other families who have been affected by Hydro One, I'd like to say THANK YOU!!!"

Complainant

"The Ombudsman overseeing municipalities is absolutely fantastic.... I sat for 23 years as a municipal councillor... for 23 years, it has been frustrating to put forth arguments about what is not allowed at the municipal level of government, only to be told it isn't going to change. Thank you for fighting to get this role, and for the protection this office will afford the taxpayers of Ontario."

Former municipal councillor

"Can't believe the speed of [your] response. Wish customer service was this good everywhere I went."

Member of public who had questions about [illegible]

Your Feedback

COMMENTS FROM SOCIAL MEDIA

"Thank you for your work on Hydro One. You have a team without equal."

"I applaud your tenacity and your stand for justice for the common folk... I again wish you and your staff the best and thank you for providing us such dedication."

"It is nice to know that there are still honest people in this world/government."

"Our Ontario Ombudsman... is a shining light in a political and bureaucratic sea of darkness. He stands tall with integrity, seeking justice and dignity for all."

"We value you and your staff for working so hard to investigate Hydro One. You find the truth and follow through and no one can disagree with you, because you have the facts!"

"Everybody, please follow @Ont_Ombudsman – he is probably the coolest public servant in Ontario. #onpoli"

"@Ont_Ombudsman In my view, you have more credibility & respect than anybody else in govt. Your work embodies concerns for ordinary citizens."

"The @Ont_Ombudsman office is driven by integrity & honesty. Thxs for the open & meaningful discussion last night [in NWT]."

"Are there any other public officials who speak the truth as publicly as @Ont_Ombudsman? This man gives me so much hope! Must be others."

"Have you ever had to contact @Ont_Ombudsman and felt ignored? I haven't either, not once. Thank you for being there!"

Your Feedback

COMMENTS FROM SOCIAL MEDIA

"@Ont_Ombudsman @HydroOne Thank you! Your office helped a lot of people who were just hitting a brick wall. Remains to be seen what changes."

"@Ont_Ombudsman We know we can count on you to keep 'em honest!"

"It's awesome seeing @Ont_Ombudsman at work. Govt without this kind of oversight is damaged goods. Just wish there was more of it federally."

"@Ont_Ombudsman Thank you for your contributions on Twitter and more widely across Ontario. I only wish hospitals would be included."

IN THE NEWS

"[Bill 8] will allow Ontario Ombudsman André Marin and his talented team of legalists to take their investigative talents to towns and cities all over Ontario.... The outspoken Ombudsman will give added oomph to current investigations. Will his dedicated staff unveil more troubling problems in other cities and towns? We won't know for a while, but at least Bill 8 has unleashed another investigative arm, and puts on guard any feeble or venal officials planning to try and muck up other towns and cities in Ontario."

"[Bill 8] is a useful initiative given [Ombudsman André] Marin's knack for attracting media coverage for his investigations and shaming governments into action."

"Under Marin's leadership, the Ombudsman's office has fearlessly and often scathingly exposed all manner of flaws and faults."

"The examples of billing errors [in the Ombudsman's Hydro One report] were shocking, even for someone like me who hears of billing errors on a daily basis."

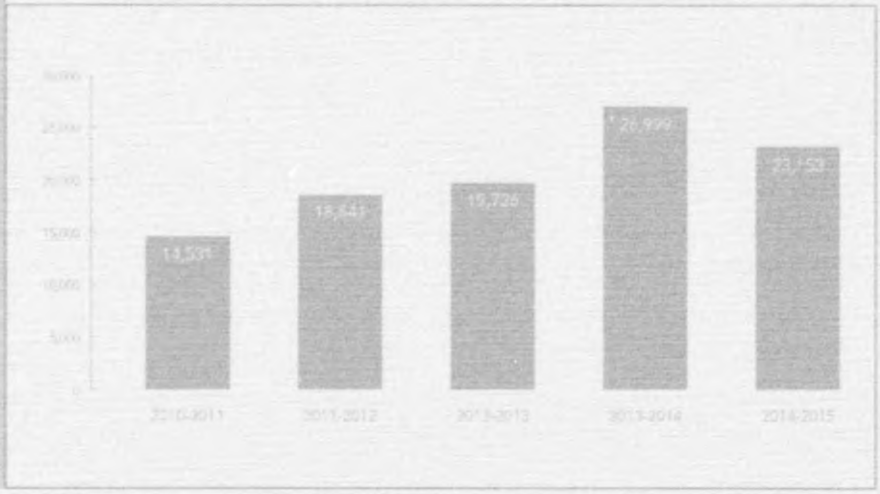
"Marin's the person who just issued a damning report on Hydro One overbilling and called his probe 'wrestling with a slippery pig.' It seems he's always in the news, standing up for the afflicted and the wronged."

"André Marin has proven himself to be a hard-working, honest advocate for the people of Ontario. I look forward to him taking on his new responsibility."

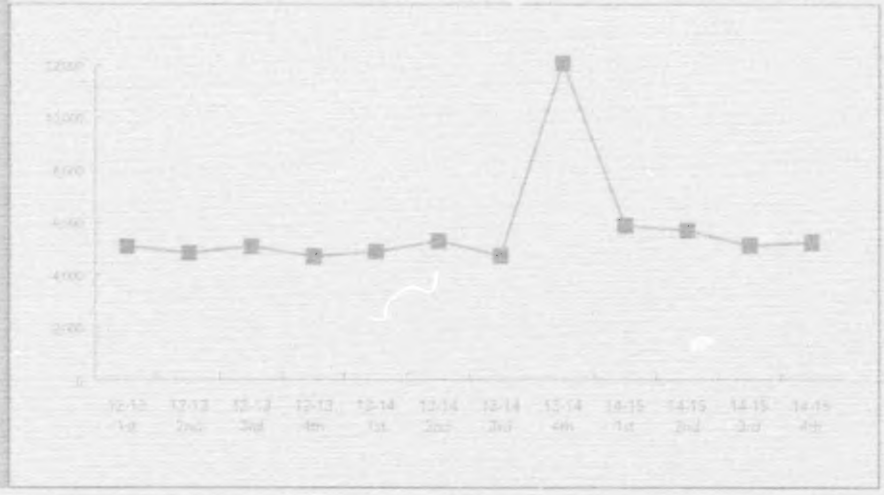
Appendix 1

COMPLAINT STATISTICS

TOTAL CASES RECEIVED, FISCAL YEARS 2010-2011 TO 2014-2015



CASES RECEIVED BY QUARTER, 2012-2013 TO 2014-2015

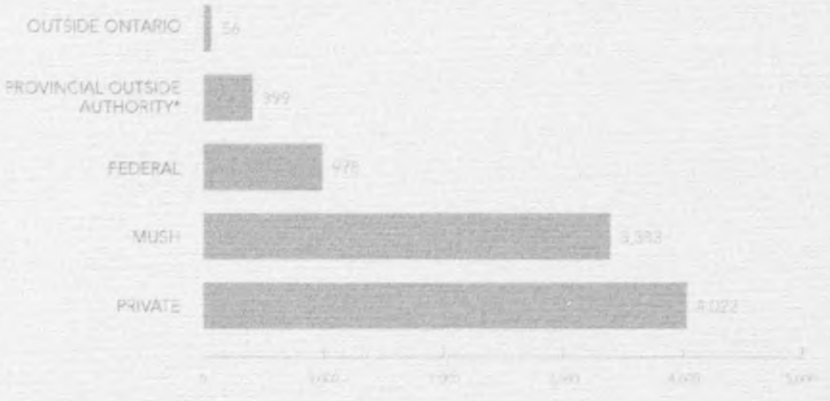


Appendix 1

COMPLAINT STATISTICS

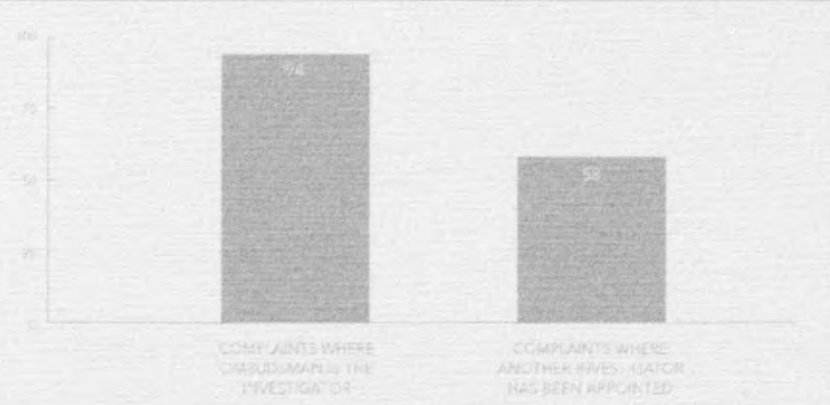
CASES OUTSIDE THE OMBUDSMAN'S AUTHORITY RECEIVED 2014-2015

TOTAL: 8,838



*For example, cases received about courts, Stewardship Ontario and Tarion.

CASES RECEIVED ABOUT CLOSED MUNICIPAL MEETINGS 2014-2015



*Note: Details of these cases will be released in our separate Open Meeting Law Enforcement Team (OMLET) Annual Report, later in this fiscal year.

Appendix 1

COMPLAINT STATISTICS

TOP 15 PROVINCIAL GOVERNMENT ORGANIZATIONS AND PROGRAMS COMPLAINED ABOUT 2014-2015*

		NUMBER OF CASES	PERCENTAGE OF ALL CASES WITHIN AUTHORITY
1	HYDRO ONE	3,499	24.82%
2	FAMILY RESPONSIBILITY OFFICE	1,167	8.28%
3	ONTARIO DISABILITY SUPPORT PROGRAM	684	4.85%
4	WORKPLACE SAFETY AND INSURANCE BOARD	481	3.41%
5	PRIVATE CAREER COLLEGES BRANCH	274	1.94%
6	DRIVER LICENSING - MEDICAL REVIEW SECTION	243	1.72%
7	DRIVER LICENSING	200	1.42%
8	DEVELOPMENTAL SERVICES PROGRAMS	160	1.14%
9	LEGAL AID ONTARIO	157	1.11%
10	ONTARIO STUDENT ASSISTANCE PROGRAM	156	1.11%
11	OFFICE OF THE PUBLIC GUARDIAN AND TRUSTEE	142	1.01%
12	COMMUNITY CARE ACCESS CENTRES	128	0.91%
13	SERVICEONTARIO	128	0.91%
14	COLLEGES OF APPLIED ARTS AND TECHNOLOGY	110	0.78%
15	ONTARIO PROVINCIAL POLICE	101	0.72%

*Excluding correctional facilities.

TOP 10 CORRECTIONAL FACILITIES COMPLAINED ABOUT 2014-2015

		NUMBER OF CASES	PERCENTAGE OF ALL CASES WITHIN AUTHORITY
1	CENTRAL EAST CORRECTIONAL CENTRE	546	3.87%
2	TORONTO SOUTH DETENTION CENTRE	422	2.99%
3	OTTAWA-CARLETON DETENTION CENTRE	410	2.91%
4	CENTRAL NORTH CORRECTIONAL CENTRE	349	2.48%
5	MAPLEHURST CORRECTIONAL COMPLEX	324	2.30%
6	HAMILTON-WENTWORTH DETENTION CENTRE	214	1.52%
7	ELGIN MIDDLESEX DETENTION CENTRE	211	1.50%
8	VANIER CENTRE FOR WOMEN	189	1.34%
9	TORONTO EAST DETENTION CENTRE	184	1.31%
10	NIAGARA DETENTION CENTRE	161	1.14%

Appendix 1

COMPLAINT STATISTICS

CASES EXCLUDING CORRECTIONAL FACILITIES RECEIVED 2014-2015, BY PROVINCIAL RIDING*

Ajax-Pickering	76
Algoma-Manitoulin	247
Ancaster-Dundas-Flamborough-Westdale	108
Barrie	164
Beaches-East York	93
Bramalea-Gore-Malton	92
Brampton-Springdale	89
Brampton West	133
Brant	140
Bruce-Grey-Owen Sound	231
Burlington	132
Cambridge	93
Carleton-Mississippi Mills	124
Chatham-Kent-Essex	105
Davenport	96
Don Valley East	91
Don Valley West	90
Dufferin-Caledon	142
Durham	153
Eglinton-Lawrence	90
Elgin-Middlesex-London	160
Essex	100
Etobicoke Centre	73
Etobicoke-Lakeshore	145
Etobicoke North	96
Glengarry-Prescott-Russell	160
Guelph	98
Haldimand-Norfolk	119
Haliburton-Kawartha Lakes-Brock	257
Halton	113
Hamilton Centre	168
Hamilton East-Stoney Creek	110
Hamilton Mountain	86
Huron-Bruce	158
Kenora-Rainy River	115
Kingston and the Islands	106
Kitchener Centre	77
Kitchener-Conestoga	100
Kitchener-Waterloo	68
Lambton-Kent-Middlesex	142
Lanark-Frontenac-Lennox and Addington	309
Leeds-Grenville	207
London-Fanshawe	134
London North Centre	140
London West	123
Markham-Unionville	26
Mississauga-Brampton South	67
Mississauga East-Cooksville	78
Mississauga-Erindale	67
Mississauga South	73
Mississauga-Streetsville	47
Nepean-Carleton	157
Newmarket-Aurora	106
Niagara Falls	138
Niagara West-Glanbrook	103
Nickel Belt	162
Nipissing	185
Northumberland-Quinte West	186
Oak Ridges-Markham	142
Oakville	78
Oshawa	146
Ottawa Centre	97
Ottawa-Orleans	90
Ottawa South	74
Ottawa-Vanier	92
Ottawa West-Nepean	87
Oxford	93
Parkdale-High Park	99
Parry Sound-Muskoka	280
Perth-Wellington	98
Peterborough	140
Pickering-Scarborough East	80
Prince Edward-Hastings	268
Renfrew-Nipissing-Pembroke	187
Richmond Hill	75
Sarnia-Lambton	168
Sault Ste. Marie	146
Scarborough-Agincourt	76
Scarborough Centre	96
Scarborough-Guildwood	127
Scarborough-Rouge River	35
Scarborough Southwest	98
Simcoe-Grey	184
Simcoe North	197
St. Catharines	111
St. Paul's	95
Stormont-Dundas-South Glengarry	175
Sudbury	154
Thornhill	70
Thunder Bay-Atikokan	123
Thunder Bay-Superior North	103
Timiskaming-Cochrane	197
Timmins-James Bay	115
Toronto Centre	150
Toronto-Danforth	95
Trinity-Spadina	135
Vaughan	85
Welland	152
Wellington-Halton Hills	102
Whitby-Oshawa	95
Willowdale	77
Windsor-Tecumseh	142
Windsor West	128
York Centre	84
York-Simcoe	172
York South-Weston	82
York West	63

*Where a valid postal code is available

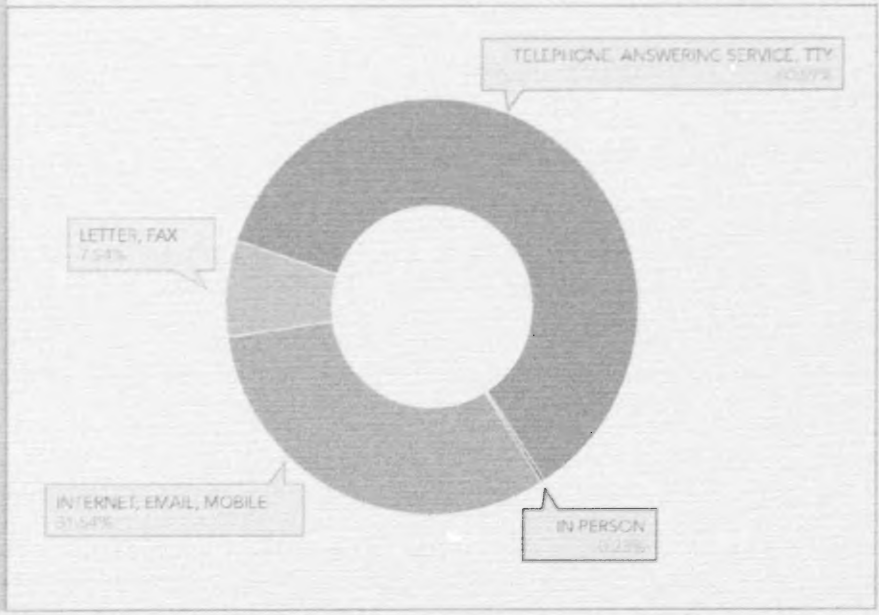
Appendix 1

COMPLAINT STATISTICS

MOST COMMON TYPES OF CASES RECEIVED 2014-2015

1	ACCESS TO OR DENIAL OF SERVICES; INADEQUATE OR POOR SERVICE
2	DECISION WRONG, UNREASONABLE OR UNFAIR
3	DELAY
4	COMMUNICATION INADEQUATE, IMPROPER OR NO COMMUNICATION
5	ENFORCEMENT UNFAIR OR FAILURE TO ENFORCE
6	LEGISLATION AND/OR REGULATIONS
7	FAILURE TO ADHERE TO POLICIES, PROCEDURES OR GUIDELINES; UNFAIR POLICY/PROCEDURE
8	BROADER PUBLIC POLICY ISSUE
9	INTERNAL COMPLAINTS PROCESS; LACK OF A PROCESS, UNFAIR HANDLING OF COMPLAINT
10	GOVERNMENT FUNDING ISSUE

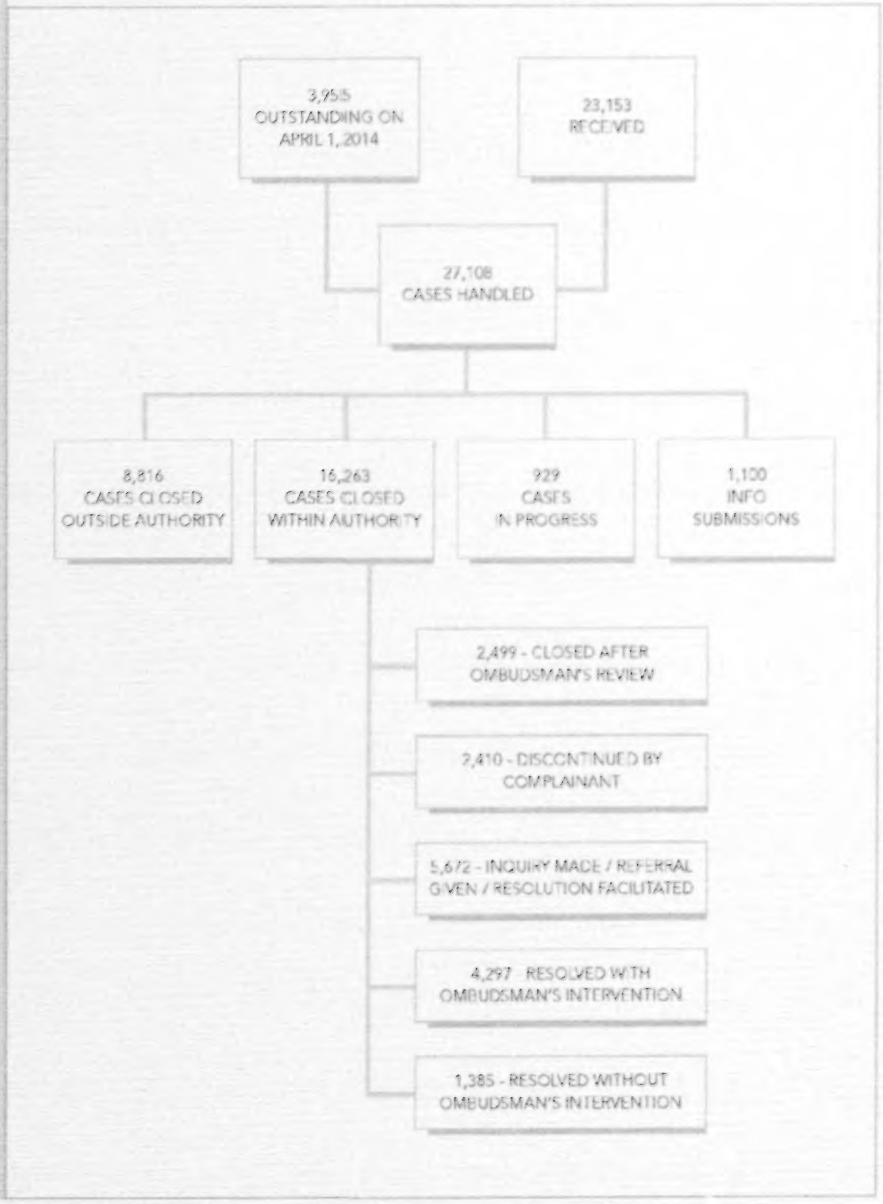
HOW CASES WERE RECEIVED 2014-2015



Appendix 1

COMPLAINT STATISTICS

DISPOSITION OF CASES 2014-2015



Appendix 1

COMPLAINT STATISTICS

TOTAL CASES RECEIVED 2014-2015 FOR PROVINCIAL GOVERNMENT MINISTRIES AND SELECTED PROGRAMS*

MINISTRY OF AGRICULTURE, FOOD AND RURAL AFFAIRS		8
MINISTRY OF THE ATTORNEY GENERAL		811
ALCOHOL AND GAMING COMMISSION OF ONTARIO	10	
ASSESSMENT REVIEW BOARD	11	
CHILD AND FAMILY SERVICES REVIEW BOARD	15	
CHILDREN'S LAWYER	98	
CRIMINAL INJURIES COMPENSATION BOARD	37	
HUMAN RIGHTS LEGAL SUPPORT CENTRE	11	
HUMAN RIGHTS TRIBUNAL OF ONTARIO	71	
LANDLORD AND TENANT BOARD	95	
LEGAL AID ONTARIO	157	
LICENCE APPEAL TRIBUNAL	17	
OFFICE OF THE PUBLIC GUARDIAN AND TRUSTEE	142	
ONTARIO MUNICIPAL BOARD	16	
SOCIAL BENEFITS TRIBUNAL	35	
SPECIAL INVESTIGATIONS UNIT	18	
MINISTRY OF CHILDREN AND YOUTH SERVICES		129
MINISTRY-FUNDED SERVICE PROVIDERS	32	
SPECIAL NEEDS PROGRAMS – CHILDREN	49	
YOUTH CUSTODY FACILITIES	28	
MINISTRY OF CITIZENSHIP, IMMIGRATION AND INTERNATIONAL TRADE		3
MINISTRY OF COMMUNITY AND SOCIAL SERVICES		2,077
DEVELOPMENTAL SERVICES PROGRAMS	160	
FAMILY RESPONSIBILITY OFFICE	1,167	
MINISTRY-FUNDED SERVICE PROVIDERS	25	
ONTARIO DISABILITY SUPPORT PROGRAM	684	
ONTARIO DISABILITY SUPPORT PROGRAM – DISABILITY ADJUDICATION UNIT	21	
MINISTRY OF COMMUNITY SAFETY AND CORRECTIONAL SERVICES		4,110
CORRECTIONAL FACILITIES	3,904	
OFFICE OF THE CHIEF CORONER	16	
ONTARIO PROVINCIAL POLICE	101	
PRIVATE SECURITY AND INVESTIGATIVE SERVICES BRANCH	14	
PROBATION AND PAROLE	40	
MINISTRY OF ECONOMIC DEVELOPMENT, EMPLOYMENT AND INFRASTRUCTURE		7
MINISTRY OF EDUCATION		56
CHILD CARE QUALITY ASSURANCE AND LICENSING BRANCH	15	
MINISTRY OF ENERGY		3,589
HYDRO ONE	3,499	
ONTARIO ENERGY BOARD	44	
ONTARIO POWER AUTHORITY	17	
MINISTRY OF THE ENVIRONMENT AND CLIMATE CHANGE		122

*Total figures are reported for each provincial government ministry including agencies and programs falling within its portfolio. Each government agency or program receiving 10 or more cases is also included.

Appendix 1

COMPLAINT STATISTICS

TOTAL CASES RECEIVED 2014-2015 FOR PROVINCIAL GOVERNMENT MINISTRIES AND SELECTED PROGRAMS*

MINISTRY OF FINANCE		235
FINANCIAL SERVICES COMMISSION	20	
LIQUOR CONTROL BOARD OF ONTARIO	12	
MUNICIPAL PROPERTY ASSESSMENT CORPORATION	76	
ONTARIO LOTTERY AND GAMING CORPORATION	67	
MINISTER RESPONSIBLE FOR FRANCOPHONE AFFAIRS		1
MINISTRY OF GOVERNMENT AND CONSUMER SERVICES		268
REGISTRAR GENERAL	63	
SERVICEONTARIO	128	
MINISTRY OF HEALTH AND LONG-TERM CARE		528
ASSISTIVE DEVICES/HOME OXYGEN PROGRAMS	42	
COMMUNITY CARE ACCESS CENTRES	128	
HEALTH PROFESSIONS APPEAL AND REVIEW BOARD	29	
LOCAL HEALTH INTEGRATION NETWORKS	15	
MINISTRY-FUNDED SERVICE PROVIDERS	27	
ONTARIO HEALTH INSURANCE PLAN	83	
ONTARIO PUBLIC DRUG PROGRAMS	57	
PERFORMANCE IMPROVEMENT AND COMPLIANCE BRANCH	25	
MINISTRY OF LABOUR		680
EMPLOYMENT PRACTICES BRANCH	33	
OCCUPATIONAL HEALTH AND SAFETY BRANCH	19	
OFFICE OF THE WORKER ADVISER	17	
ONTARIO LABOUR RELATIONS BOARD	13	
WORKPLACE SAFETY AND INSURANCE APPEALS TRIBUNAL	99	
WORKPLACE SAFETY AND INSURANCE BOARD	481	
MINISTRY OF MUNICIPAL AFFAIRS AND HOUSING		34
MINISTRY OF NATURAL RESOURCES AND FORESTRY		81
MINISTRY OF NORTHERN DEVELOPMENT AND MINES		6
MINISTER RESPONSIBLE FOR THE 2015 PAN AND PARAPAN AMERICAN GAMES		5
MINISTRY OF TOURISM, CULTURE AND SPORT		25
MINISTRY OF TRAINING, COLLEGES AND UNIVERSITIES		615
COLLEGES OF APPLIED ARTS AND TECHNOLOGY	110	
ONTARIO COLLEGE OF TRADES	23	
ONTARIO STUDENT ASSISTANCE PROGRAM	156	
PRIVATE CAREER COLLEGES BRANCH	274	
SECOND CAREER	26	
MINISTRY OF TRANSPORTATION		566
DRIVER LICENSING	200	
DRIVER LICENSING - MEDICAL REVIEW SECTION	243	
METROLINX/GO TRANSIT	18	
VEHICLE LICENSING	45	

*Total figures are reported for each provincial government ministry including agencies and programs falling within its portfolio. Each government agency or program receiving 10 or more cases is also included.

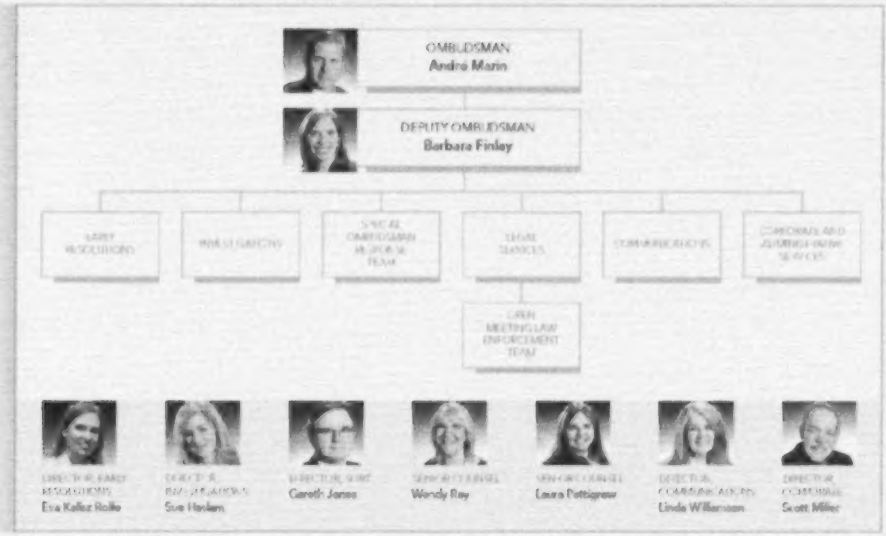
Appendix 2

HOW WE WORK

COMPLAINT RECEIVED BY EARLY RESOLUTIONS TEAM
WITHIN OMBUDSMAN'S MANDATE AND PERSON HAS USED LEGISLATIVE AVENUES OF COMPLAINT
YES
NO
REFER TO APPROPRIATE RESOURCES
RESOLUTION ATTEMPTED
RESOLVED OR NO FURTHER ACTION NECESSARY
NOT RESOLVED
INVESTIGATION
SORT INVESTIGATION (COMPLEX, HIGH-PROFILE, SYSTEMIC ISSUES)
NOTICE TO GOVERNMENTAL ORGANIZATION
FORMAL INVESTIGATION
FULL FIELD INVESTIGATION
FINDINGS AND REPORT AND/OR RECOMMENDATIONS (WHERE WARRANTED)

Appendix 3

ABOUT THE OFFICE



Early Resolutions: The Early Resolutions team operates as the Office's front line for receiving, triaging and assessing complaints, providing advice, guidance and referrals to complainants. Early Resolution Officers use a variety of conflict resolution techniques to resolve complaints that fall within the Ombudsman's jurisdiction.

Investigations: Complaints that cannot be easily resolved are referred to Investigations. The Investigations team conducts issue-driven, focused and timely investigations of individual complaints and systemic issues.

Special Ombudsman Response Team (SORT): The Special Ombudsman Response Team conducts extensive field investigations into complex, systemic, high-profile cases. SORT investigators work in collaboration with Early Resolutions, Investigations and Legal Services, and additional staff are assigned to SORT as needed.

Legal Services: Led by the Office's two Senior Counsel, the Legal Services team ensures that the Office functions within its legislated mandate and provides expert advice to the Ombudsman and staff in support of the resolution and investigation of complaints, the review and analysis of evidence and the preparation of reports and recommendations. It also co-ordinates the work of the **Open Meeting Law Enforcement Team (OMLET)**, which investigates complaints about closed municipal meetings (received pursuant to the *Municipal Act*) and engages in education and outreach with municipalities and the public with regard to open meetings.

Communications: In addition to co-ordinating the Ombudsman's reports, brochures, other publications and videos, the Communications team maintains the Ombudsman's website and social media presence, assists in outreach activities, and provides support to the Ombudsman and staff in media interviews, press conferences, speeches, presentations and public statements.

Corporate and Administrative Services: The Corporate and Administrative Services team supports the Office in the areas of finance, human resources, administration and information technology.

Appendix 4

FINANCIAL REPORT

During the fiscal year 2014-2015, the total operating expenditures for the Office were **$11.413 million**. Miscellaneous revenue returned to the government amounted to $50,000, resulting in net expenditures of **$11.363 million**. The largest categories of expenditures relate to salaries, wages and employee benefits at **$9.170 million**, which accounts for **80.3%** of the Office's annual operating expenditures.

SUMMARY OF EXPENDITURES 2014-2015

	($ IN THOUSANDS)
SALARIES AND WAGES	$7,495
EMPLOYEE BENEFITS	$1,675
TRANSPORTATION AND COMMUNICATIONS	$359
SERVICES	$1,539
SUPPLIES AND EQUIPMENT	$345
ANNUAL OPERATING EXPENSES	**$11,413**
LESS: MISCELLANEOUS REVENUE	$50
NET EXPENDITURES	**$11,363**